Joint submission to the Office of the High Commissioner for Human Rights' report on sustainable HIV responses with regard to the human rights of people living with, at risk of or affected by HIV

14 March 2025

Submitting organisations:

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 the United Nations.

UnMode: is an international non-governmental organization with a network nature. Geography of representation: countries of the region of Central and Eastern Europe and Central Asia. UnMode's mission is to ensure access to justice as an effective human rights tool for prisoners/ex-prisoners with a history of drug use in the region.

Penal Reform International (PRI) is a non-governmental organisation working globally to promote criminal justice systems that uphold human rights for all and do no harm. We work to make criminal justice systems non-discriminatory and protect the rights of disadvantaged people. We run practical human rights programmes and support reforms that make criminal justice fair and effective. PRI holds ECOSOC Special Consultative Status since 1993. Registered in The Netherlands (registration no 40025979), PRI operates globally with offices in multiple locations.

International Drug Policy Consortium (IDPC) is a network of over 190 members from all over the world with broad and diverse expertise, including community-led networks, grassroots groups, advocacy NGOs, as well as major international organisations. IDPC was founded in 2006 and, since 2011, has been an independent, not-for-profit organisation legally registered in the UK. In 2020, IDPC became legally registered in the Netherlands and Ghana.

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Introduction

Harm Reduction International (HRI), UnMode, Penal Reform International (PRI) and International Drug Policy Consortium (IDPC) welcome the opportunity to provide inputs ahead of the OHCHR report on "sustainable HIV responses with regard to the human rights of persons living with, at risk of or affected by HIV". Drawing on the submitting organisations' experience and expertise, this document will provide valuable information to the High Commissioner with a specific focus on people deprived of liberty[1].

Unless stated otherwise, the information provided in this submission comes from HRI's Global State of Harm Reduction 2024 (GSHR 2024).

a) What frameworks, legal reforms, policies and strategies are in place that are key to protect the rights of persons living with, at risk of or affected by HIV and ensure that responses to HIV are sustainable and equitable?

The provision of harm reduction in prison is central to achieving UNAIDS' goal of ending HIV by 2030 and meeting Sustainable Development Goals.[2] However, punitive drug policies continue to hinder prevention efforts. The interlinkages between drug policy and the overincarceration of people who use drugs create high-risk environments in prisons for the spread of infectious diseases, including HIV.

Punitive drug policies continue to be a major contributor to prison overcrowding and the disproportionate imprisonment of marginalised communities, including people who use drugs. According to the World Health Organisation (WHO), approximately 30 million people spend time in prison per year worldwide.[3] Out of the 11.5 million people currently in prison,[4] an

[1] For this submission, 'people deprived of liberty' refers to people held in prisons. The term 'prisons' is used to describe places of criminal legal detention, where individuals are held either in pre-trial or under sentence. It does not include other places of deprivation of liberty where people are at high risk of contracting HIV, and access to health and harm reduction services are also needed, including immigration or police detention or mental health institutions.

[2] UNAIDS. (2021). Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. UNAIDS. https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy

[3] WHO (n.d) People in prisons and other closed settings. WHO. https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-in-prisons

[4] Fair, H. and Walmsley, R. (2024). World Prison Population List (14th ed.). World Prison Brief; Institute for Crime & Justice Policy Research, Birkbeck, University of London. p.2 https://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_14th_edition.pdf

HARM REDUCTION INTERNATIONAL

UNMODE COMMUNITY MOVEMENT

PENAL REFORM INTERNATIONAL

idpc

estimated 2.2 million people globally are held for drug offences, with 22% (470,000 people) for drug possession for personal use.[5] Estimates indicate that up to 90% of people who inject drugs will be imprisoned at some point in their life.[6]

Drug use and risk-associated behaviours increase in prison, leading to a greater prevalence of HIV infections. While imprisonment tends to reduce the likelihood of injecting drug use, other individuals continue, start using additional drugs or initiate injecting drugs unsafely. On average, 32% of people in prison use drugs globally (ranging between 3.4% to 90% depending on the region) compared to 5.6% in the community.[7] Drug use in prison is often done under unsafe conditions, including exchange of needle and syringe, which increases the risks of contracting HIV and other infectious diseases. For example, sharing injecting equipment has been linked to HIV outbreaks in prisons in Iran, Lithuania, Thailand, the UK and Ukraine.[8] Risks associated to drug use in prison can be exacerbated even further by other risk behaviours, including unsafe sex and sexual violence, which also increase the likelihood of contracting HIV.[9] Women in prison are more likely to use drugs, and their populations often have higher prevalence rates for HIV (double or more) when compared to male prisoners.[10]

The over-representation of people who use drugs, with usually intersecting vulnerabilities and layers of discrimination, make them more likely to suffer from poor health and are at high risk of becoming seriously ill if contracting HIV or other disease.[11] This is compounded by

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[5] For more information, see Penal Reform International and Thailand Institute of Justice. (2023). Global Prison Trend 2023. https://www.penalreform.org/global-prison-trends-2023/

[6] UNAIDS. (2014). The Gap Report. UNAIDS. p.21. https://www.unaids.org/sites/default/files/media_asset/05_Peoplewhoinjectdrugs.pdfc

[7] UNODC (2024), World Drug Report 2024: Key Findings and Conclusions, p.45, UNODC, Vienna. www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2024.html; Austin. A., et al., (2023). Factors associated with drug use in prison: A systematic review of quantitative and qualitative evidence. International Journal of Drug Policy, vol. 122, e104248. p.1. https://doi.org/10.1016/j.drugpo.2023.104248; Norman, C. (2022). A global review of prison drug smuggling routes and trends in the usage of drugs in prisons. Wires Forensic Science, vol. 5, no.2, e1473. https://wires.onlinelibrary.wiley.com/doi/10.1002/wfs2.1473.

[8] Dolan, K; Moazenb, B; Noorib, A; Rahimzadehb, S; Farzadfarb, F and Harigac F. (2015). People who inject drugs in prison: HIV prevalence, transmission and prevention. International Journal of Drug Policy, Vol. 26, 12-15. p.13 https://pubmed.ncbi.nlm.nih.gov/25727258.

[9] WHO (n.d) People in prisons and other closed settings. WHO. https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-in-prisons

[10] WHO (n.d) People in prisons and other closed settings. WHO. https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-in-prisons

[11] Hartung. D.M., et al., (2023), 'Fatal and non-fatal opioid overdose risk following release from prison: A retrospective cohort study using linked administrative data', Journal of Substance Use and Addiction Treatment, vol. 147, e208971; Vera Institute of Justice, 'National trends and racial disparities, Vera, New York; www.vera.org/publications/overdose-deaths-and-jail-incarceration/national-trends-and-racial-disparities; Harm Reduction International, (2021), The Harm of Incarceration, HRI, London. https://hri.global/publications/theharms-

suboptimal prison conditions, such us prison overcrowding, limited access to clean water, inadequate sanitary conditions, a lack of healthcare -including HIV testing and treatment-, to name a few,[12] which makes places of detention a high-risk environment for the transmission of diseases.

Additionally, evidence indicates an association between recent imprisonment and increased HIV and HCV acquisition among people who inject drugs, and several studies suggests that the imprisonment of people who inject drugs could be a contributor to the transmission of infectious diseases after release.[13]

Despite harm reduction being recognised as a central element of the right to health[14] and a key strategy to combat HIV,[15] HRI's data shows that people deprived of liberty continue to be severely underserved:

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of-incarceration-the-evidence-baseand-human-rights-framework-for-decarceration-and-harm-reduction-in-prisons; Binswanger, I.A., et al., (2012), 'Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors', Addiction Science and Clinical Practice, vol. 7, no. 1, p.3. https://pubmed.ncbi.nlm.nih.gov/22966409.

[12] For more details on prison conditions, see Penal Reform International and Thailand Institute of Justice, (2023), Global Prison Trends 2022. www.penalreform.org/global-prison-trends-2022.

[13] Montanari, L, Royuela, L, Hasselberg, I. and Vandam, L. (2022). Prison and Drugs in Europe, current and future challenges. European Monitoring for Drugs and Drugs Addiction. p.36. https://www.euda.europa.eu/publications/insights/prison-and-drugs-in-europe_en

[14] UNODC (2023). UN Common Position on supporting the implementation of the international drug control through effective inter-agency collaboration. UNODC, Vienna. p 5. https://unsceb.org/united-nations-system-common-position-supporting-implementation-international-drug-control-policy#:~:text=The%20common%20position%20reiterated%20the,to%20the%20world%20drug%20problem; UN System, (2021), Common position on Incarceration, UN System, New York, https://www.unodc.org/res/justice-and-prison-reform/nelsonmandelarules-GoF/UN_System_Common_Position_on_Incarceration.pdf; UN Human Rights Council, (2016), Revised UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), Rule 24 (1), OHCHR, Geneva; https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf; United Nations Office on Drugs and Crime, et al., (2006), Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response, UNODC, Vienna; https://www.unodc.org/pdf/HIV-AIDS_prisons_Oct06.pdf; UN General Assembly, (1990), Basic Principles for the Treatment of Prisoners, Principle 9, UNGA, New York, https://www.ohchr.org/en/instruments-mechanisms/instruments/basic-principles-treatment-prisoners; UN General Assembly, (1982), Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, A/RES/37/194, Principle 1, UNGA, New York, https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-medical-ethics-relevant-role-health-personnel#:~:text=Principle%205-,It%20is%20a%20contravention%20of%20medical%20ethics%20for%20health%20personnel,or%20mental%20health%20or%20the

[15] UNAIDS (2024). Global AIDS targets 2025 for people who use drugs: Where are we now? UNAIDS. p. 2 and 7; https://www.unaids.org/sites/default/files/media_asset/global-AIDS-targets-2025-for-people-who-use-drugs-where-are-we-now_en.pdf; WHO (2022). Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key population. WHO. p.30, 52, 59, among others.

- Only 11 countries have Needle and Syringe Program (NSP) in at least one prison.[16] This is just 12% of the 93 countries that provide NSPs to people outside of prison.
- Naloxone is available in at least one prison in just 11 countries across Europe,[17] North America[18] and Oceania.[19]
- Opioid Agonist Therapy (OAT) in prisons is available in at least 60 countries[20], compared to 93 in the community.

Data from 2017-2024 shows that only 55 countries were providing condoms and lubricants in prisons and other closed settings.[21] While most countries provide HIV testing and treatment, there is still some barriers to access those services in prison.[22] For example, HIV testing is reported to be widely available in prisons across Europe, with many countries offering testing during medical examinations. However, mandatory HIV testing is still reported in some prisons in European countries, which is not justified based on public health principles.[23] In Latin America and Ester and Southern Africa, all countries provide HIV testing and treatment inside prisons, although there are many documented barriers to access, particularly for women who use drugs, including humiliating and punitive treatment.[24] In the case of Asia, the information is more scattered. Although UNDP reported that none of the province's 43 prisons, including 5 women's prisons, provide HIV services, information collected by HRI indicates that at least one NGO, Nai Zindagi, offers harm reduction services in 24 prisons (23 in Sindh and 1 in

https://www.who.int/publications/i/item/9789240052390; WHO, UNODC, UNAIDS (2009) WHO, UNODC, UNAIDS technical guide four countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. P.6. https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

[16] Armenia, Canada, Germany, Iran, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland, Tajikistan and Ukraine. It is relevant to notice that France has NSPs program in one prison, however, this is an unsanctioned NSP operating without formal approval from the government and therefore not included in HRI's Global State Harm Reduction data analysis.

[17] Estonia, France, Germany, Italy, Ireland, Lithuania, Norway and Ukraine.

[18] Canada and the US

[19] Australia

[20] Aotearoa New Zealand, Afghanistan, Albania, Algeria, Australia, Austria, Armenia, Belgium, Bosnia and Herzegovina, Canada, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Kenya, Kosovo, Kyrgyzstan, India, Indonesia, Iran, Iceland, Ireland, Italy, Israel, Latvia, Lebanon, Lithuania, Luxembourg, Macau, Malta, Malaysia, Mauritius, Moldova, Montenegro, Morocco, Netherlands, North Macedonia, Norway, Puerto Rico, Poland, Portugal, Romania, Serbia, Seychelles, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Turkey, Tanzania, Ukraine, United Kingdom, United States of America and Vietnam.

[21] UNAIDS. (2024). The urgency of now: AIDS at a crossroads—Global AIDS update 2024. UNAIDS. p. 48. https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024

[22] For more details see The Global State of Harm Reduction 2022 https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2022/

[23] see for example, EMCDDA. (2022). Insights. Prison and Drugs in Europe. Current and futute challenges. P 70 y ss. https://www.euda.europa.eu/publications/insights/prison-and-drugs-in-europe_en

[24] For more details see The Global State of Harm Reduction 2022 https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2022/

Khyber Pakhtunkhwa), including three female and three are juvenile prisons. Harm reduction services provided are HIV testing, counselling on safer sex, linkages to antiretroviral treatment (ART) for HIV, adherence support, baseline investigation to initiate ART and linkages to hepatitis C treatment.

(b) What measures did you take or need to be taken to ensure the protection of human rights in settings, which are transitioning to a more sustainable HIV response, such as in contexts of conflict or disasters?[25]

The right to health of people deprived of liberty must be protected under any circumstances, including in contexts of war and humanitarian crisis. People in prisons should be prioritised in emergency responses to guarantee their safety and the continuity of access to healthcare and other essential services.

However, this has not been the case in many conflicts, including after the full-scale Russian invasion of Ukraine. Since the war started in February 2022, people deprived of liberty have been disproportionately impacted by the war. Despite attacks on essential infrastructure and disruption of essential services, including medical care and harm reduction, at least 11 prisons were not evacuated, and people deprived of liberty endured numerous human rights violations, including extrajudicial killings, ill-treatment, and torture. Following the Russian occupation of the Kherson Region, from June 2022, around 100 people detained in the occupied territory were deprived of OAT, which they have received before the invasion, and which is prohibited in the Russian Federation.

Local organisations confirmed that around 2,002 people detained in prisons in Kherson and Mykolaiv Regions of Ukraine were illegally transferred to Russian territory in November 2022, in breach of international human rights and humanitarian law. After tireless efforts to locate their whereabouts, organisations documented that all people transferred were ill-treated or tortured during their transportation to Russian territory. This degrading treatment was replicated upon detention in Russian prisons, where people were also segregated from the rest of the prison population, and deprived of contacts with the outside world and had no access to safe water, sanitation, or medical care. This is compounded by the general poor prison conditions in Russia, with reports indicating widespread ill-treatment and a high rate of

[25] Unless stated otherwise, all information provided here comes from Joint submission to the Special Rapporteur on Health's report on harm reduction for peace and development. https://hri.global/publications/harm-reduction-for-sustainable-peace-and-development-joint-submission-to-the-sr-on-health-on-prisons/

transmission of infectious diseases, such as tuberculosis and HIV; with one third of all deaths in prisons being associated with HIV.

While some transferred individuals were released from Russian correctional facilities after serving their sentences, they were immediately re-detained under immigration powers, imposed administrative deportation and sent to immigration detention centres. None of the immigration centres to which civilian prisoners from Kherson were transferred have adequate medical units, medicaments, and qualified medical specialists. As documented by Unmode and other organisations, Ukrainian prisoners living with HIV found themselves in the most vulnerable position, as the detainees in the immigration detention centres are not provided with the necessary antiretroviral therapy (ART). According to Unmode, an exception is that of Volgorad, where everyone who needed it received treatment for both HIV and tuberculosis.[26]

c) How can domestic funding be improved to ensure universal and equitable access to HIV services?

According to HRI's report and monitoring, harm reduction in Low and Middle Income (LMI) countries is facing its most profound crisis. Consistently underfunded, with only 6% of estimated resources needed,[27] US and other countries cuts to foreign aid threatens the sustainability of harm reduction programmes. Harm reduction in prison is particularly vulnerable. Currently these programmes are operating on a limited scale with many relying heavily on external funding and support from international donors. This dependence on international funding makes these programmes particularly vulnerable to changes in the global funding landscape. Any shifts in donor priorities, budget cuts, or policy changes can affect the sustainability of harm reduction efforts in prisons.

As international fund finishes, some countries are not able to transition to domestic fund. In Romania, NSP, OAT and prevention programmes for groups at increased risk of HIV were dramatically reduced once funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) ended, and the government was not able to take over and sustain the financing of services. In contrast, some prisons in Moldova started offering harm reduction services in 2000 through international funding and technical assistance. Over the years, the

[26] While the location and conditions of many of those who were placed in immigration detention could be traced, and many of them were able to leave Russia, the location and conditions of some of them remain unknown due to the lack of official communication channels and censorship.
[27] Catherine Cook and Gaj Gurung. (2024). The Cost of Complacency: A harm Reduction Finding Crisis. Harm Reduction International. https://hri.global/flagship-research/funding-for-harm-reduction/cost-of-complacency/

country developed a supportive regulatory environment and started funding services from the state budget and has also expanded services. Harm reduction programmes in prisons in Mauritius are funded by the government, mainly through the ministry of health and other ministries' budgets, with contribution from the Global Fund for specific items.

According to PRI, in Uganda, as in many other nations in the region, the suspension of USAID funding has severely impacted the provision of HIV/AIDS and sexual and reproductive health services within prisons, creating a dire situation, particularly for women. The reduction of healthcare staff has made it difficult to adequately attend to all prisoners in need, affecting the follow-up care for HIV and TB patients, including those released from prison. This disruption in treatment increases viral loads, exacerbating health conditions and undermining efforts to manage the disease. While HIV itself may not be fatal, the lack of proper nutrition and vulnerability to opportunistic infections pose serious threats to survival. Furthermore, the fear of being unable to continue treatment prevents individuals from effectively suppressing the virus, worsening the overall health crisis in prisons.

Therefore, incorporation of harm reduction in prison into state budget is key to ensure sustainability of services and protect them from fluctuations in external funding. National scale up and linkage to national HIV and public health programmes are crucial to ensure equity across prisons and between prisons. It is equally important to guarantee the continuity of care upon release.

(d): What are the key barriers to the promotion, protection and monitoring of human rights in relation to the HIV response? How can they be overcome?

Prisons provide an opportunity for universal screening and 'micro-elimination' of communicable diseases among a high-risk population,[28] and populations that are usually hard to reach by health and social services outside in the community. However, barriers in accessing the already lacking harm reduction interventions hinders the positive outcomes that may come from those key interventions.

[28] For example, in France, where HCV is 10 times more prevalent in prisons than outside, one remand prison has succeeded in eliminating the virus for the past seven years, attributed to a proactive screening policy. In Virginia, USA, where HCV prevalence is 10 times higher among people in prison than the general population, a pharmacist-led telemedicine HCV clinic achieved a 97% cure rate among 1,040 people in prison with chronic HCV who were treated between 2020 and 2022.

The GSHR 2024 has identified the following barriers that prevent people in prison from accessing harm reduction:

Uneven distributions of harm reduction services: states should ensure equal access to health services for all people in prison. However, HRI's data shows that the limited harm reduction services in prison are unevenly distributed across countries and regions: Apart from Canada and Iran, all identified NSPs in prisons are in Eurasia and Western Europe. The availability of OAT also varied widely between regions, with most of the services concentrated in Western Europe and Eurasia. In Asia, only five countries provide OAT and Puerto Rico is the only country in Latin America and the Caribbean providing OAT in at least one prison. No country in Western and Central Africa provide OAT in prison.

In some countries, OAT is limited to people who were prescribed this treatment before entering prison. This is the case in some Eurasian countries, including Albania, Bulgaria, Latvia, Montenegro and Serbia. Similar restrictions apply in Lebanon, Macao (China) and Mauritius. Even when OAT is available to everyone, regardless of whether someone has been on OAT before prison, there can be increased barriers for those who start OAT while in prison, such as treatment waitlists, which may lead to leading to treatment withdrawal.

Perceived risk of sanctions or loss of rights or privileges: One of the most reported barriers experienced by people in prison is the fear of punishment or loss of rights or other privilege resulting from disclosing drug use. They worry that such admission might result in disciplinary actions or jeopardize their chances of accessing home detention, curfew, release on temporary licence or parole.

In Romania for example, once someone enters a drug treatment programme, they are reportedly declared unfit to work while in prison, which means they will lose their income and cannot participate in meaningful activities. In Indonesia, research found that people participating in OAT programmes in prison were perceived by both prison staff and peers to be engaged in illicit drug use. They were heavily stigmatised; they were seen as lazy, poor, dirty and unproductive and were presumed to have HIV. Similarly, in England and Scotland, service users have reported that while people who disclose use of heroin on admission to prison are offered access to services, those who disclose drug use later are met primarily with a punitive response and are often suspected of selling drugs or other activities which violate prison rules.

The introduction of laws prohibiting drug consumption and sexual relations in prisons, abstinence and drug-free approaches, and a lack of support from staff and the general population also act as barrier to scaling up harm reduction interventions in prisons. For

example, in Australia, unions for prison staff are strongly against prison-based NSP and wield considerable power over aspects of prison policies which they believe -despite a lack of evidence- could compromise their health.

Lack of confidentiality and anonymity: Sates should ensure complete confidentially of any medical condition, treatment, and healthcare accessed by people in prison, including access to harm reduction interventions, HIV treatment and services for infectious diseases.[29] However, the reality in many prisons often falls short due prison conditions and the lack of independency of medical staff, which leads to privacy and confidentiality breaches.

In Moldova, uptake of OAT is believed to be limited by confidentiality breaches as well as stigma and a prison subculture that informally regulates access. Those who accept methadone treatment are frequently subject to bullying and isolation, directed by leaders among the prison population. Despite NSP being available in most Moldovan prisons (34 sites, across 15 out of 17 prisons), a survey in 2020 found 22% of people who inject drugs in prison shared injecting equipment, suggesting that the lack of anonymity in accessing the service may be a deterrent.

Specific barriers for women in prison: Human rights standards prescribe that women require specialised and tailored treatment programmes to address drugs use and drug dependence. The design and delivery of service should consider prior victimisation and trauma, the special needs of pregnant women and women with children, as well as their diverse cultural backgrounds.[30] Women in prison should also receive medical screening on entry and healthcare during imprisonment, including mental healthcare, HIV treatment, care and support, support in relation to suicide and self-harm and preventive healthcare services which are responsive to the specific needs of women.[31] Yet, harm reduction is particularly limited for women in prison, they are not gender-sensitive and are usually concentrated in men's facilities. For example, the only therapeutic community in Moldovan prisons is in a male facility. The two prisons in Ireland that have consultant-led, 'in-reach' drug dependence services only

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[29] Nelson Mandela Rules 9, 31-32, Bangkok Rules, Rule 8; CESCR General Comment No. 14, particularly para. 8 and 12; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, A/HRC/56/52, para. 21; Report of the Working Group on Arbitrary Detention on its mission to Botswana, A/HRC/54/51/Add.1, para. 86; Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, CAT/OP/MNG/1, para. 96.

30 UN Rules for the Treatment of Women Prisoners and Noncustodial Measures for Women Offenders (the Bangkok Rules), particularly Rules 6 – 18; Convention on the Elimination of All Forms of Discrimination against Women, particularly Articles 2, 12 and 14.

31 Concluding observations on the fifth periodic report of Kazakhstan, CEDAW/C/KAZ/CO/5, para. 40 (e); Concluding Observations on the eighth periodic report of Indonesia, CEDAW/C/IDN/CO/8, para 44 (a), Concluding Observations on the tenth Periodic report of Uruguay. CEDAW/C/URY/CO/10, para 42 (c), among others.

accommodate men. In Georgia, OAT (for detoxification) is not available in the women's prison. Instead, women in need of OAT are temporarily transferred to a treatment facility in a male prison where they share a psychiatric ward with men. As a result, uptake is low among women who accounted for only 2 of the 754 people that benefited from prison-based OAT in 2021. Discriminatory attitudes from staff and feelings of shame that lead some women to hide their drug use or dependency means it is likely that many women in prison do not access the services available in the system and deal with withdrawal on their own. In Eastern and Southern Africa, civil society has documented widespread barriers to accessing HIV testing and treatment in prison for women who use drugs, including humiliating and punitive treatment by prison staff and services only being available in a limited number of facilities.

Other marginalised people in prison: States should protect the right to respect and fulfil the right to health with dignity and non-discriminatory manner.[32] However, marginalised groups, including foreign nationals, LGBTQI+ people, children, Black, Brown, ethnic minority and Indigenous people and people engaged in sex work, usually face stigma and discrimination that hinder access to harm reduction in prison. The challenges these marginalised populations face in prisons are often similar to the issues they experience in the community, including services that are not responsive to their needs. In Morocco and Armenia, for example, standard services are generally provided to all individuals without consideration of the specific needs of women, LGBTQI+ people or other groups. Sex workers who use drugs face barriers accessing services due to the layered stigma surrounding drug use, sex work and sexual orientation, which in many countries are all criminalised to varying degrees. In Indonesia, trans and gender diverse sex workers who use drugs who are in prison are failed by existing harm reduction structures. In some countries, such as Ireland, Zambia and the US, trans and gender diverse people in prison are held in long periods of lock-up and solitary confinement, often on grounds of protection, which limits their access to all services in prison, including harm reduction.

Other barriers for scaling up services: prison healthcare should be organised in close relationship with the national health system in a way that ensures continuity of treatment and care, including for HIV, tuberculosis, other infectious diseases and drug dependence. [33]

[32] Among others; Universal Declaration of Human Rights, particularly Articles 1 and 25; International Covenant on Economic, Social and Cultural Rights, particularly Article 12; International Covenant on Civil and Political Rights, particularly Articles 6-7, 9-10 and 26, and Convention on the Elimination of All Forms of Discrimination against Women, particularly Articles 2, 12 and 14.

[33] cite standards

Although the WHO, UNODC[34], and human rights standards[35] recommend that the most effective way of doing this is by prison healthcare being managed by the national health authority rather than the prison administration, in many countries, prison health remains under the jurisdiction of ministries of justice, interior or home affair in many countries, which oversees the penitentiary system. As consequence, security approaches are prioritised over prison health and the provision of harm reduction can be fragmented.

In Germany, for example, prison healthcare is under the ministry of justice in the 16 Länder (states), and care for people with opioid dependency is scattered. Some Länder have almost no waiting list for prison-based OAT and others provide hardly any treatment at all, meaning people on OAT will not be able to continue treatment in prison. In Armenia, while the Penitentiary Medical Centre collaborates with healthcare institutions that provide harm reduction, significant issues in continuity of care lead to interruptions in the services for people upon detention and after release from prison. The failure to transfer responsibility for prison health to the regional health services in Spain is seen as a barrier to the expansion of harm reduction in prisons.

Countries that have transferred responsibility for prison health to the health ministry include Norway, Finland, Italy, England and Wales and Kazakhstan. In April 2024, Portugal proposed a gradual transfer, with the aim of ensuring people have uninterrupted access to healthcare in prison and upon release by 2030.

Please indicate innovative approaches and technologies pursued to promote equitable and affordable access to HIV responses.

A good example of innovation and good practice can be found in Ukraine, which open it first NSP in Odesa's prison in 2023 in partnership with the NGO FREE ZONE. This is also an example of how to integrate meaningful participation of people deprived of liberty in the development and implementation of harm reduction interventions in prison. As reported by the GSHR 2024, the program was implemented after having conducted a survey among prison population about drug use and interest in harm reduction services. The survey revealed that 50% of respondents had used drugs and 40% were interested in participating in an NSP, after

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[34] UNODC and the WHO Regional Office for Europe, (2013), Good governance for prison health in the 21st century, UNODC and WHO. https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf

[35] The Nelson Mandela Rules, Rule 24.-25

which a comprehensive service package was developed. This included training for people in prison and prison staff, and technical support for peer consultants who FREE ZONE later employed. By July 2024, 592 people had received around 19,500 services from the NSP, and 13 people in prison became peer workers to support social reintegration once people were released. Following the success of this model, another prison facility in Ukraine has recently proposed a similar programme.

(j) What are the top priorities and actionable recommendations in relation to human rights for a sustainable HIV response for your country or institution?

International human rights obligations and standards bind states to provide equal access to quality harm reduction services and essential medicines to all people, including people deprived of liberty, on a voluntary basis and without discrimination. In line with such obligations, and the information provided through this submission, we encourage the OHCHR to recommend Member States to:

- Decriminalise drug use and apply health and human rights-centred, and evidence-based responses to drug use to reduce prison populations and promote the right to health;

- Introduce alternative to incarceration, decongestion and early release measures to reduce prison overcrowding, ensuring that drug-related offences are not subject to any blanket restrictions in decongestion and early release mechanisms;

- Recognise harm reduction as an essential element of the right to health and incorporate it into prison health programmes and policies;

- Maintain and scale up harm reduction services for all people in prison and ensure that are provided under the basis of voluntary, informed and free consent and complete confidentiality of any medical condition, treatment, and healthcare accessed by people in prison, including access to harm reduction interventions, HIV treatment and services for infectious diseases;

- Ensure adequate prison conditions and other underlying determinants of health for all people in prison, including access to safe and potable water and adequate sanitation, adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information,

including on sexual and reproductive health and women's specific hygiene needs by, among others, allocating sufficient financial and human resources;

- Eliminate all legal and policy barriers and stigmatising and discriminatory practices that limit the access to essential medicines, healthcare and treatment for people deprived of liberty;

- Improve the coordination between the National Health Service and prisons to ensure continuity of care and treatment for individuals upon release, or consider transferring responsibility for prison healthcare to the national health authority instead of the prison administration;

- Maintain disaggregated data about distribution of harm reduction and essential medicines in prisons; and

- Ensure that people can continue accessing harm reduction services and HIV testing and treatment upon release without discrimination.

HARM REDUCTION INTERNATIONAL

UNMODE COMMUNITY MOVEMENT

PENAL REFORM INTERNATIONAL

idpc