HARM REDUCTION INTERNATIONAL

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

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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 the United Nations.

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Introduction

Harm Reduction International (HRI) welcomes 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 organisation's experience and expertise, this document will provide valuable information to the High Commissioner with a specific focus on harm reduction and people who use drugs. Full analysis of the situation goes beyond the space of this submission. More information is available on HRI's Global State of Harm Reduction 2024 (GSHR 2024), Global State of Harm Reduction 2022 (GSHR 2022), The Cost of Complacency: a harm reduction funding crisis, among others.

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?[1]

Harm reduction strategies are central to achieving UNAIDS' goal of ending HIV by 2030; however, the provision of harm reduction services is still suboptimal, and people who use drugs continue to be left behind in HIV responses.

People who use drugs and other key populations remain disproportionately affected by HIV despite overall progress in the global response in the last decades. Out of the 39.9 million

[1] Unless stated otherwise, all information provided here comes HRI's Global State of Harm Reduction 2024.

people living with HIV, 9.3 million people are still not accessing life-saving treatment. In 2023, an estimated 1.3 million people acquired HIV, and approximately, 630 000 people died of AIDS-related illnesses, including 76.0000 children.[2] At least half of all people from key populations are not being reached with basic HIV prevention services. Men and women who inject drugs, gay, bisexual men and other men who have sex with men and transgender people are particularly neglected in prevention programmes.[3]

Key populations -including people who use drugs- and their sexual partners continue to bear a disproportionate burden of the pandemic. As reported by UNAIDS, in 2022, the relative risk of acquiring HIV was 14 times higher for people who inject drugs, 23 times higher for gay men and other men who have sex with men, nine times higher for sex workers, and 20 times higher for transgender women than in the wider adult (aged 15–49 years) population globally.[4] These risks are further compounded for individuals whose identities and vulnerabilities intersect due to stigma and marginalisation.

Approximately, one in eight people who inject drugs, or about 1.6 million individuals are living with HIV, with the highest proportion of infections reported in South-West Asia (29.4%), Eastern Europe (25.6%) and Southern Africa (22.3%), with rates twice as high as the global average (11.6 %).[5] It is also estimated that people who use drugs contributed to half of the new HIV in 2022 globally. People who inject drugs also carry a high burden of other infections, and nearly one in every two people who inject drugs is living with hepatitis C (HCV), with liver disease due to HCV being a major cause of drug-related deaths, accounting for more than half of the total number of deaths attributed to the use of drugs in 2019.[6]

Among people who inject drugs, there are some groups of particular risk. While men outnumber women in injecting drug use, women carry a higher burden of health and social consequences. Women are 1.2 times more likely than men to be living with HIV. This is due to heightened vulnerability due to gender violence and power structures that can lead to unsafe sexual and injecting behaviours. For example, women who inject drugs are likely to have a male intimate partner who initiated them into drug use and may rely on them for injection. Women who use, drugs are at higher risk of experiencing gender-based violence and sexual abuse perpetrated by both their intimate partners and by other people who use drugs around them, law enforcement officers and drug service providers.[7] Young people who inject drugs also face significantly higher risks of contracting HIV and HCV compared to adults who inject drugs. They are 50% more likely to acquire HIV and HCV than their adult counterparts. In №rth America, young people are disproportionately affected by overdoses and drug poisonings, and overdose is now the third leading cause of death among this age group. LGBTQ+ people have historically been a marginalised and criminalised group, which has posed them with an increased risk of acquiring HIV while lacking access to life-saving treatment. With most harm

[2] UNAIDS, 'The Urgency of Now, AIDS At A Crossroads', 2024 Global AIDS Update (2024), P 8
[3] See section "HIV prevention for people from key populations" on UNAIDS 2024 Global AIDS Update, P. 35
[4] UNAIDS 2024 Global Update
[5] UNODC, World Drug Report 2024 (2024). P 44
[6] Ibid.
[7] UNODC, World Drug Report 2024, P. 48

reduction programmes still reliant on international funding, the growing number of foreign agents and anti-LGBTQI+ laws pose a significant threat to the continuation of HIV-related services and support for key population groups.

WHO, UNAIDS and UNODC have recognised harm reduction as part of the key comprehensive package of evidence-based interventions for HIV prevention, treatment and care for people who inject drugs; however, they remain severely underserved. As of 2024, HRI's Global State of Harm Reduction reported that:

- **93 countries provide at least one Needle and Syringe Program (NSP)**, one more country than the previous report in 2022, with Brazil joining the list.[8] However, the availability of NSPs still falls significantly short of the global demand. The latest review finds 190 countries and territories where injecting drug use has been documented, meaning people who inject drugs in 97 countries are unable to access an NSP anywhere.
- **Opioid Agonist Therapy (OAT) programmes are available in 94 countries**, compared to 88 in 2022.[9] Despite the increase in the provision of OAT, the coverage varies across regions. Western Europe has the highest coverage with almost 70 OAT clients per 100 people who inject drugs, followed by Oceania and South Asia. Moderate coverage is registered in №rth America, where an estimated 21% of people who inject drugs receive OAT. In the rest of the regions, coverage is low, being particularly critical in Central Asia, Eastern Europe, Eastern and Southern Africa and West and Central Africa. Across these regions, fewer than 2% of people who inject drugs have access to OAT. OAT is prohibited by federal law in Russia despite around 90% of its 1.3 million people who inject drugs using opioids and needing access to the service.
- **Only 18 countries have at least one Drug Consumption Room (DCRs)**, two more countries than 2022, namely Colombia and Sierra Leona. Distribution across regions remain uneven, as the majority of DCRs are concentrated in Western Europe.
- **Take-home naloxone programmes are now available in 34 countries**, a decrease of two countries since 2022.
- **108 countries include harm reduction in national policies,** up from 105 in 2022. However, the scope and comprehensiveness of harm reduction policies vary significantly across nations. Some countries, such as Ethiopia and Malawi, have limited harm reduction in their policies, which only includes OAT in their national HIV plans. In contrast, Zimbabwe's HIV plan includes three harm reduction services (OAT, NSP and naloxone distribution). Malawi has explicit references to harm reduction in several national policy documents, including the health sector's strategic plan as well as the country's specific plans on drugs, HIV, hepatitis and sexually transmitted infections (STIs). In Brazil, supportive references to harm reduction appear in several national plans (on drugs, HIV, hepatitis, and STIs), including references to different services

[8] In Bulgaria, NSPs are available again in two cities (Sofia and Plovdiv), after having closed in 2020 due to a lack of domestic funding. In Accra, Ghana, a pilot NSP is operational as of 2024. Although Dominican Republic and Ghinea registered NSPs in 2022, services could no longer be confirmed in 2024.
[9] New countries include Egypt, Kuwait, the United Arab Emirates, Peru, Benin and Sierra Leone.

(OAT, NSP, infectious disease care and services for non-injecting drug use). This is in line with international recommendations for more comprehensive responses.

Additionally, there are other practices associated to drug use to which traditional harm reduction interventions may not be appropriate to the need of people using drugs. That is the case of the sexualised drug use, which involves both sexual and drug-related high-risk behaviours including multiple sexual partners, the use of multiple drugs together, among others.[10] For example, chemsex, the practice of using specific drugs to enhance and prolong sex (often involving group sex), is on the rise in Asia and has been associated with a higher risk of contracting HIV and other infections, according to studies from Malaysia, Hong Kong, Thailand and China.[11] Common drugs used by people engaged in chemsex in Asia typically include methamphetamine, ecstasy (MDMA), poppers (alkyl nitrites), ketamine and gamma-hydroxybutyrate or gamma-butyrolactone (GHB/GBL) and will often involve the use of more than one type of drug during a chemsex session.[12] Consequently, the chemsex scene may include various forms of drug use, such as ingesting, snorting, smoking and injecting, with many risks associated with their use and conventional harm reduction strategies may not adequately address the specific challenges associated with chemsex-related substance use.

People engaging in chemsex are an important target group for PrEP and PEP, and appropriate service provision can be key to access to these preventive medications.[13] The few harm reduction services for chemsex are focused on gay, bisexual, and other men who have sex with men (GBMSS). However, these are not the only people who practice chemsex, whose needs may be overlooked. This highlights the importance of robust and tailored health interventions in reducing the risk of infections and providing effective care and 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?

Harm Reduction International uses human rights standards to challenge rights violations and promote the protection of human rights. The first step we took is by creating a database[14] that compiles human rights standards from UN human rights bodies and mechanisms. It aims to provide experts, activists, and civil society in general with a tool to make the case for harm reduction and promote human-rights based approaches to drug policies. This database serves

[10] HRI (2021), Chemsex and harm reduction for gay men and other men who have sex with men. https://hri.global/wp-content/uploads/2022/10/HRI_Briefing_Chemsex_July_2021_Final-1.pdf

[11] HRI (2022), Global State of Harm Reduction, P.56

[12] Ibid.

[13] Sewell J, Cambiano V, Speakman A, Lampe FC, Phillips A, Stuart D, Gilson R, Asboe D, Nwokolo N, Clarke A, Rodger AJ. Changes in chemsex and sexual behaviour over time, among a cohort of MSM in London and Brighton: Findings from the AURAH2 study. Int J Drug Policy. 2019 Jun;68:54-61. doi: 10.1016/j.drugpo.2019.03.021. Epub 2019 Apr 15. PMID: 30999243.

[14] https://hri.global/un-human-rights-standards-database/

as a living document that will be updated as standards are renewed, or new standards are adopted.

We also have published a Prison Monitoring Tools[15], where on this report we identify some of the most important human rights and public health standards relating to HIV, HCV and tuberculosis in prisons, and the vital role of harm reduction provision in ensuring them. The report recognises that the right to health and freedom from ill treatment are inseparable, which places human rights-based prison monitors, particularly those with a preventative mandate, in a unique and critical position to consider these issues. It notes, however, that this is not yet occurring in an adequately systematic or comprehensive manner, and provides specific recommendations to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the United Nations Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).

Alongside the report, we have created a monitoring tool to assist human rights-based prison monitoring mechanisms and other prison monitors to generate better informed, more consistent and sustained monitoring of issues relating to HIV, HCV, TB and harm reduction in prisons, and ultimately to help prevent situations and conditions that can lead to ill treatment in this context from occurring in the first place.

HRI also carries out monitoring on the funding for harm reduction services as part of promoting the right to health of people who use drugs. In 2022, HRI's research identified just USD 151 million in harm reduction funding in low- and middle-income countries from both international donors and governments. This represents only 6% of the USD 2.7 billion required annually by 2025. This leaves a funding gap of 94%, which compares to a funding gap of 29% for the overall HIV response. Harm reduction in low- and middle-income countries remains heavily reliant on international donors, and recent US funding cuts have highlighted the precarious nature of this as a source of support for life-saving services.

Domestic funding for harm reduction in LMI countries amounted to USD 49.7 million, representing 33% of all harm reduction funding identified in 2022. Domestic investment in harm reduction accounted for a mere 0.4% of all domestic funding for HIV in 2022. The amount and proportion of harm reduction funding from domestic budgets have been reduced since 2019. It appears that a step backwards has been taken, and we are further away from achieving a sustainable harm reduction response than we were in 2019. The amount of domestic harm reduction spending identified by this report is a paltry 1.7% of the estimated harm reduction resource needed by 2025.

Increased domestic investments in quality, human rights-based harm reduction programmes will be crucial if global targets are to be met. To successfully transition from international donor funding, governments must make harm reduction funding available to community-led, community-based and civil society organisations. Social contracting is a term used to describe the process where government resources are directed to non-governmental entities to provide services.5 It is also referred to as social provision of services or public financing for

[15] HRI(2016), HIV, HCV, TB and Harm Reduction in Prisons – Monitoring Tool.

programmes and services implemented by non-governmental organisations. Since harm reduction is largely provided by community-led, community-based, and civil society organisations in many countries, ensuring that mechanisms are in place to allow government resources to be directed to these organisations is especially important. The three main funding models used by governments for social contracting are:

1. Results-based financing: Payments are made upon achievement of results. This can work for larger organisations that have sufficient core funding to finance their activities in advance but may exclude smaller organisations with limited funds.

2. Procurement and contracting: Payments are made at set times based on a contracted level of service provision and timeline. Reimbursements from insurance schemes can also fall into this category.

3. Grants (or capitation model): Funds are provided in advance, and organisations report back on activities. This model can provide some flexibility and indicate a level of trust in grantees. It is also used where the number of clients a service is likely to reach within a time period is already known.

On the disaster context, integrated and person-centred services demonstrated resilience during the COVID-19 pandemic. For example, in Mali, ARCAD Santé Plus integrated HIV and COVID-19 services through the CovidPrev project, continuing HIV testing and treatment while providing COVID-19 prevention and adapting to physical distancing requirements. Similarly, Pink House in Bulgaria continued outreach and support during lockdowns, offering food, hygiene materials, and health information when drop-in centres were closed.[16]

Upholding international standards, such as the UN Nelson Mandela Rules on prison health, ensures access to harm reduction and HIV services in detention and prison settings. These rules reinforce the need for continuity of care regardless of context.

In the MENA region, emergency preparedness for HIV services has focused on inclusive, coordinated responses during crises. Plans by the Middle East Harm Reduction Association (MENAHRA) have helped maintain service continuity through pre-crisis planning, staff training, and mobile service models. Countries like Libya and Pakistan have introduced multi-stakeholder accountability frameworks to ensure the involvement of key populations, particularly people who use drugs, in national HIV strategies. Similar participatory approaches are being implemented in Egypt, Jordan, Lebanon, Morocco, Tunisia, and Yemen.[17]

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

[16] HRI (2021) Integrated harm reduction services. https://hri.global/publications/integrated-harm-reduction-services/

[17] Middle East Harm Reduction Association, (2023), Emergency Preparedness Plans for HIV and Harm Reduction Service Providers, MENAHRA, Beirut.

The funding landscape for harm reduction programs is at a critical juncture, particularly in middle and low-income countries (LMICs). Despite harm reduction showing to be highly cost-effective, cost-saving and efficient in preventing HIV and HCV among key populations, the funding remains severely inadequate. According to HRI's report *The Cost of Complacency: a harm reduction funding crisis*, as of 2022, a total of USD 22.4 billion was made available for the HIV response in LMICs, leaving a 29% gap to meet estimated need by 2025. The funding gap for key population is even larger than the funding gap for the HIV response, standing at an estimated 90% in 2022. HRI identified USD 151 of harm reduction funding in 2022, amounting to just to just 6% of the USD 2.7 billion needed annually by 2025, leaving a funding gap of 94%.[18]

Countries still rely heavily on international donor funding, which comprised 67% of the total harm reduction funding in 2022.[19] After the Global Fund, the largest donor is PEPFAR, which provided USD 74 million. The total PEPFAR expenditure on programmes for people who inject drugs amounted to USD 7.9 million in 2022, with most of this recorded expenditure (81%) going through HIV preventions programs for this specific population.[20] In 2022, PEPFAR funds supported the provision of OAT to 27,000 people in seven countries (India, Kenya, Kyrgyzstan, South Africa, Tajikistan, Tanzania and Uganda), №tably, in January 2024 the USA announced a pause on all foreign assistance, including programs supported by PEPFAR. This triggered one of the more profound crises of harm reduction ever, with severe implications for people who use drugs and modelling indicating an increase in overdoses and HIV infections as a direct impact of the freeze. In addition, 'stop work orders' to multilateral agencies receiving PEPFAR support such as UNAIDS, UNODC and pooled mechanisms such as the Robert Carr Fund (RCF) are affecting activities at secretariat, country office and local level, disrupting services and crucial supportive processes that have implications for people who use drugs such as community-led monitoring and the roll-out of sustainability road maps. Given high level of uncertainty with international funding prone to shift in priorities, political leadership and ideology, the need for scaling up domestic funding for a more sustainable response is key.

At a domestic level, investment for HIV has increased over the last decades. However, the slowdown in domestic funding since mid-2010s and the recent flattening of funding levels since 2018 are concerning trends. In 2022 the overall domestic funding was 3% lower than in 2021 and accounted for 60% of the total HIV investment. The limited domestic funding available is directed to HIV treatment such as procurement of antiretroviral (ARV) medication, clinical services etc, with few domestic investments directed to support prevention for key population, including harm reduction. Although harm reduction funding appeared to be increasing in 2019, HRI observed a decrease in identified funding for countries with previously large investments, including Iran and Vietnam.[21] As a result, domestic funding for harm reduction is around 33% of all harm reduction funding identified in 2022, a substantial reduction from 2019. To put it in a perspective, domestic investment in harm reduction accounted for a mere 0.4% of all

[18] HRI (2024), The Cost of Complacency: A Harm Reduction Funding Crisis, P. 5-6
[19] Ibid.
[20] Ibid, P.27
[21] HRI, Cost of complacency. P 15

domestic funding for HIV in 2022; and the amount of domestic harm reduction spending identified by HRI's report is a paltry 1.7% of the estimated harm reduction resource need by 2025.

There are different avenues to integrate HIV services in the domestic funding- and such integration not only increase investment but saves money and strengthen health system. These avenues include increased funding of government department managing HIV response, inclusion of comprehensive HIV treatment and prevention services in the national health insurance scheme, direct funding to civil society and community-led organizations through social contracting and other strategic initiatives. The direct increased allocations on HIV will enhance to prevent new HIV infections more effectively and improve the readiness of health system, integration in national health insurance will ensure universal access to the services and social contracting will enhance the community system, a critical component to health system. For example, co-financing can have a catalytic effect on increasing government ownership of national harm reduction programmes. That is the case of Indonesia, from which the Global Fund has obtained a co-financing commitment that amounts to USD 20.1 million domestic funding for HIV prevention programmes for people who use drugs and their sexual partners over three years period (2023-2026). However, this represents only 3% of Indonesia total co-financing commitment for HIV and would amount a mere 9% per day per person who injects drugs. Another tool to encourage domestic investment used by the Global Fund is the matching funds mechanism, which allows the Global Fund to use its influence as a donor to incentivise investment in evidence-based prevention programmes for key population, including harm reduction, in cases where political will is often lacking.

A good example of how domestic funding can work is the case of Community Oriented Substance Use Programme (COSUP) in Tshwane, South Africa, which represents an innovative model of harm reduction funding that combines procurement contracting and grant funding. The Chair of the South African Network of People who Use Drugs (SANPUD) sits on COSUP's central management team and peer educators from the community of people who use drugs are central to the programme and services. The City of Tshwane makes scheduled payments based on the Service Level Agreement (SLA) and contract timeline. However, COSUP also has access to the flexibility and up-front payments that are typical of grants. The level of trust and historical dealings with the Department of Family Medicine meant that the funding was flexible, and line items were adjusted as priorities shifted. Unlike other municipalities, interventions for drug use in Tshwane are funded by the Department of Health.[22] The first agreement was signed in 2016. A total of 2,957 people who use drugs were enrolled in COSUP and attended 19,533 counselling, social work or support sessions between 2016 and 2020. More than 600 people initiated OAT, around half of whom were self-funded, and the other half were city funded. After a national lockdown was declared in 2020 due to the COVID-19 pandemic, COSUP continue providing services, which confirms the model's inherent adaptability, collaboration and innovation in addressing healthcare challenges during

[22] For more details see, HRI's report COSUP in South Africa- A model for domestic harm reduction funding. https://hri.global/publications/cosup-in-south-africa-a-model-for-domestic-harm-reduction-funding/

time of crisis. Between 2020 and 2023 the programme focused on Phase II aimed to consolidate services and align COSUP with the National Draft Plan and other policy documents as well as capacitate and train more people who use drugs. In early 2024, In early 2024, the City of Tshwane entered into a new SLA worth USD 6.8 million with the University of Pretoria to continue the COSUP programme until 2026.

The domestic funding increment requires technical financing knowledge and curated budget advocacy to convince the policy makers to make more investment in HIV and harm reduction. There are positive examples across the globe where budget advocacy has successfully increased domestic funding and have channelled the funding through social contracting. The advocacy however requires resources; and the international agency must provide such resource on budget advocacy. The resources can be core funding to advocacy organizations and flexible advocacy grant.

(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?

There are many legal, policy, cultural, economic and practical barriers to protecting and promoting the rights of people who use drugs in relation to the HIV response, a full analysis of which goes beyond the space of this report; but which have been analysed at length by communities, civil society, academics and UN agencies such as UNAIDS, OHCHR and WHO. The following paragraphs will provide a brief, summarised review of key barriers.

Criminalisation of key populations (such as people who use drugs, sex workers, and people living with HIV) is in itself an extremely significant barrier to monitoring state practices, as well as to protecting and promoting human rights in relation to the HIV response. With regards to drug use specifically, literature clearly shows the impact of criminalisation on a vast array of fundamental rights. Among many others, criminalisation prevents access to harm reduction and other health services by instilling fear and stigma among people who use drugs;[23] thus impinging on the promotion of the right to health of people who use drugs. Criminalisation also leads to (over)incarceration, which in turn is an almost insurmountable barrier to accessing HIV services and enjoying fundamental rights.

Besides criminalisation, **stigma and discrimination**, including in healthcare settings, create hostile environments that deter key populations from seeking care.[24] For example in Egypt, a 2023 study found that healthcare staff in hospitals regularly stigmatise and discriminate against people who use drugs, directly impacting access to services.[25] In many contexts these are exacerbated byc ultural and religious taboos that further marginalise women, migrants, and LGBTQI+ people, often making them invisible in national HIV strategies.[26] For example, in Algeria, religious barriers prevent people from seeking NSP services because using drugs

[23] HRI, (2024) Global State of Harm Reduction 2024, p.154–156.
[24] Ibid, P.92-95.
[25] Ibid. P. 159.
[26] Ibid. P.154.

is considered a major sin.[27] In Iran, unrealistic expectations from family and society, as well as stigma and the intertwining of treatment with ethical and religious principles, are identified as the most significant socio-cultural barriers to harm reduction and HIV treatment.[28]

Criminalisation, stigma and discrimination have broader impacts. On one hand, they prevent the **meaningful participation** of civil society and communities in the development, monitoring and implementation of policies, in contravention of fundamental human rights and with an impact on the effectiveness of policies.[29] In some contexts, this is exacerbated by shrinking civic space and repression of civil society. This is particularly apparent in Eastern Europe and Central Asia. Organisations in Georgia, Russia, Kazakhstan and Tajikistan indicated that civil society in their countries is under threat for delivering or being involved in harm reduction services and advocacy; while the growing number of foreign agent and anti-LGBTQI+ laws poses a significant threat to the continuation of HIV-related services and support for key population groups, particularly in countries where the response relies on international donors.[30].

On the other hand, they obstacle the **collection of complete and updated data**, creating a vicious cycle of lack of reporting and thus luck of adequate policy responses. The lack of disaggregated data is particularly evident, to capture the situation and needs of people who use drugs who experience intersectional forms of discrimination, such as women, people belonging to racial and ethnic minorities, indigenous people, and LGBTQI+ individuals.

At a national level, the lack of comprehensive, updated and disaggregated data on drug law enforcement, including stops and searches has mainly been associated with State's failure to collect data and/or unwillingness to release such information. Even when data is collected on several grounds - such as ethnicity, gender and age - it is presented in a siloed way that hinders its analysis with an intersectional approach. Such lack of data is mirrored at the international level. As already indicated in other submissions,[31] the Annual Report Questionnaire (ARQ) - the international data-collection mechanism used by UNODC to collect evidence on the state of the "world drug problem" – continues to attract criticism around lack of impact and human rights indicators.[32] The data collected through this mechanism is used to produce what is supposed to be the most authoritative resource on current developments in drug policy globally: UNODC's annual World Drug Report. However, this questionnaire does not measure

[27] Alihalassa, S., (2024), 'Global State of Harm Reduction survey response 2024, Algeria'.
[28] Mallik, S., et al., (2021), "An undercover problem in the Muslim community": A qualitative study of imams' perspectives on substance use', Journal of Substance Abuse Treatment, vol. 123, e108224.
[29] HRI, (2024) Global State of Harm Reduction 2024, p.155.
[30] Ibid, P. 137.
[31] Among others see Joint submission by HRI and Release to the Office of the High Commissioner for Human Rights for the preparation of the 2024 report on "Promotion and protection of the human rights and fundamental freedoms of Africans and of 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 (1 April 2024).
[32] Submission by Harm Reduction International and Release ahead of the 2021 report, available here: https://www.ohchr.org/en/calls-for-input/2020/promotion-and-protection-human-rights-and-fundamental-freedoms-africans-and;

many impacts – including human rights impacts - of drug policies with an intersectional approach. 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.

As recommended by experts, a good way to collect accurate data would be to include the data collected by all UN agencies and bodies as well as civil society working on drug policy.[33] All published data at the national level which records trends on ethnicity should also disaggregate by gender and age and other prohibited grounds to reveal the experiences and disproportionate impact of drug law enforcement on specific groups.

The lack of complete and disaggregated data, coupled with stigma, discrimination and marginalisation, translate in a paucity of services tailored to the needs of specific groups within key populations, such as people in prison, women, transgender people, and migrants who use drugs. Services are frequently designed for adult cisgender men and do not consider the unique experiences or risks faced by other groups. For example:

- In some countries, trans and gender diverse people in prison are held in long periods of lock-up and solitary confinement, often on grounds of protection. This limits their access to all services in prison, including harm reduction. This has been reported in Ireland, Zambia and the USA.[34]
- One-third of all women in prison globally are incarcerated for drug offences. Punitive measures of drugs and drug use disproportionately affect women and gender-diverse people who use drugs and face multilayered discrimination.
- 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.[35]
- In Georgia, women needing OAT are transferred to male prisons, deterring access.[36]
- 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[37]

[33] Bewley-Taylor, Dave and Nougier, Marie. (2018) Measuring the 'world drug problem': ARQ Revision. Beyond traditional indicators? Doi http://fileserver.idpc.net/library/GDPO%20Working%20Paper%20No3%20012018.pdf.
[34] HRI, (2024) *Global State of Harm Reduction 2024*, Prison Chapter. p.83.
[35] ALCS (Association de Lutte Contre le Sida) (Morocco) and Hovhannisyan N (Armenia), (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'
[36] HRI, (2024) Global State of Harm Reduction 2024, Prison Chapter. P.82.
[37] Harm Reduction International, Unmode and European Prison Litigation Network, (2024), Joint Submission to the Special Rapporteur on Health's report on Harm Reduction for peace and development, HRI, London.

- For indigenous people, accessibility and acceptability of services are negatively impacted by, among others, the lack of culturally appropriate options which explicitly integrate spirituality, holistic healing and wellness care into OAT, as well as the absence of specialised expertise and training (including intergenerational trauma).[38]

Among the many groups facing unique barriers are young people. As further detailed in HRI's *Global State of Harm Reduction 2024,*[39] the lack of youth-specific harm reduction services, coupled with the absence of youth-friendly approaches, significantly limits young people's ability to access needed care; in turn, this often results in low engagement and poor outcomes. In South Africa for example, the lack of youth-specific harm reduction services means that young people, particularly young women, often end up in facilities not designed to meet their needs; leaving them vulnerable to violence and abuse, not only from partners but also from law enforcement officers who coerce young women to provide sex in order to avoid arrest. In Ireland, the scarcity of youth-specific services further exacerbates the challenges young people face, while stigma and legal fears hinder young people's access to the limited support on offer. This is especially the case in rural Irish areas where young people who use drugs often struggle to find the support they need.

Dearth of funding and politicised resistance to harm reduction remain key barriers to promoting human rights in the context of HIV services; often resulting in low-quality services. For example, despite evidence that low-dead space syringes are a cost-effective tool to decrease HIV and HCV prevalence among people who inject drugs, HRI mapping found that low- and middle-income countries are less likely to distribute low-dead space syringes.

The slight global increase in the number of countries where harm reduction is explicitly included in policy documents does not reflect the harsh realities that people who use drugs experience. For example, in Mozambique, where OAT is included in the national HIV plan, there have been reports of police arresting people for carrying injecting equipment. In Iran, which mentions harm reduction in its national HIV policy, the government executed 459 people in 2023 for drug-related offences, the highest number since 2015. In South Africa, the Networking HIV and AIDS Community of Southern Africa reported 600 human rights violations against people who use drugs in just three months in 2023 (including assaults and unlawful arrests).

Ways to overcome barriers include:

- Decriminalising drug use and reforming drug laws, as an essential step to reduce stigma and enable access to services;
- Promote and protect peer-led services and community leadership, to create culturally safe spaces and improve trust in service delivery.
- Training healthcare workers in human rights-centred, inclusive approaches, to improves the quality and accessibility of care.

[38] HRI, Global State of Harm Reduction 2024, p. 70.
[39] Ibid, p.98.

- Introducing accountability frameworks, such as those in Libya and Pakistan, to help integrate rights-based responses and meaningful engagement of people who use drugs into national HIV strategies.[40][41]
- As indicated in previous sections, increase sustainable funding of harm reduction and other health services, particularly at the domestic level.

Civil society, and community-led human rights organizations play a vital role at the forefront in promoting, protecting and monitoring human rights in HIV response. The activism in HIV response on human rights protection and promotion has been exemplary at all levels: local, national and international. In addition to passionate leadership and collaborations, the consistent funding for the organizations on advocacy has been crucial. The funding has supported to production of evidence, training people on human rights and able to mobilize them when needed, hold meetings with the policymakers and be part of the crucial decision-making space and the ability to play a watchdog role.

The funding for community-led response has lagged behind in HIV response. The major donors, such as Global Fund and PEPFAR, are not able to fund the community up to their commitment and target. PEPFAR had target to divert 70% of their funding to local partners through direct prime awards by the end of 2020. This target had not been reached by the beginning of 2022, and progress in shifting funding to local partners working on HIV prevention considerably lagged behind those delivering care and treatment with only 53% of prevention funding going to local partners in 2022. Similarly, in 2020, the Global Fund had USD 30.4 million of the USD 54.0 million budget for comprehensive prevention programmes, for people who inject drugs went to civil society organisations. Almost one-third of this (USD 9.3 million) went to international NGOs or international faith-based organisations with only USD 5.1 million going to local community-based organisations.

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

Innovative harm reduction strategies can play a crucial role in enhancing service quality and extending outreach to individuals who –due to discrimination and stigmatisation- typically do not engage with conventional health and social services. While this response will highlight some examples, it is important to note that it is not exhaustive. For a more comprehensive and in-depth analysis of latest development in harm reduction please consult HRI's Global State of Harm Reduction series and publications on innovation in harm reduction webpage here

Low dead space syringes and needles (LDSS) is one such tool. Direct sharing of needles and syringes account for most HIV and HCV infections among people who inject drugs in many countries. A recent modelling study estimated that removing the transmission risk due

[40] Middle East Harm Reduction Association, (2023), Regional Consultation Meeting on TB, MENAHRA, Beirut.
[41] HRI, (2024) *Global State of Harm Reduction 2024*, Middle East and North Africa Chapter. P.163.

to injecting drug use could prevent 43% of all new HCV infections globally.[42,43] Low Dead Space Syringes (LDSS) minimise the volume of residual blood in syringes, reducing the risk of transmitting bloodborne viruses like HIV and Hepatitis C (HCV) when shared.[44] They are innovative because they modify syringe design to reduce blood retention, addressing a direct pathway for HIV transmission.

Research shows LDSS are highly effective: Modelling shows that LDSS use could result in a decrease both for HIV and HCV prevalence.[45,46] Furthermore, the results of a recent threshold analyses indicated that compared to HDSS, detachable LDSS would only need to reduce the risk of virus transmission by 0.26% to be cost saving and 0.04% to be cost-effective in a high-income setting.[47] Although sufficient coverage of NSP should be prioritised at all times, there is an argument to be made that switching people who inject drugs from HDSS to LDSS should be included in comprehensive blood borne virus prevention programmes, as it could increase the effectiveness of NSPs even when coverage is inadequate.[48]

LDSS are also cost-effective, as their implementation could lead to savings in long-term HIV treatment costs: the results of threshold analyses indicated that compared to HDSS, detachable LDSS would only need to reduce the risk of virus transmission by 0.26% to be cost-saving and 0.04% to be cost-effective in a high-income setting.[49]

Integrated and person-centred services, while not new, remain an innovative approach, and one that should be further promoted to reduce HIV infections and safeguard the rights of people who use drugs.[50] Integrated harm reduction services are sites or organisations that provide one or more 'traditional' harm reduction services (such as OAT or NSPs) alongside

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[42] Trickey A, Fraser H, Lim AG, Peacock A, Colledge S, Walker JG, et al. The contribution of injection drug use to hepatitis C virus transmission globally, regionally, and at country level: a modelling study. Lancet Gastroenterol Hepatol 2019;4(6):435–44.

[43] HRI, (2023) Low dead space syringes: Analysis and benefits for people who use drugs. p.7 https://hri.global/publications/low-dead-space-syringes-analysis-and-benefits-for-people-who-inject-drugs/

[44] HRI, (2023) Low dead space syringes: Analysis and benefits for people who use drugs. p.7 https://hri.global/publications/low-dead-space-syringes-analysis-and-benefits-for-people-who-inject-drugs/

[45] Vickerman P, Martin NK, Hickman M. Could low dead-space syringes really reduce HIV transmission to low levels? International Journal of Drug Policy 2013;24(1):8–14

[46] Hancock E, Ward Z, Ayres R, Neale J, Hussey D, Kesten JM, et al. Detachable low dead space syringes for the prevention of hepatitis C among people who inject drugs in Bristol, UK: an economic evaluation. Addiction 2020;115(4):702–13.

[47] Hancock E, Ward Z, Ayres R, Neale J, Hussey D, Kesten JM, et al. Detachable low dead space syringes for the prevention of hepatitis C among people who inject drugs in Bristol, UK: an economic evaluation. Addiction 2020;115(4):702–13.

[48] Zule WA, Cross HE, Stover J, Pretorius C. Are major reductions in new HIV infections possible with people who inject drugs? The case for low dead-space syringes in highly affected countries. International Journal of Drug Policy 2013;24(1):1–7.

[49] Hancock E, Ward Z, Ayres R, Neale J, Hussey D, Kesten JM, et al. Detachable low dead space syringes for the prevention of hepatitis C among people who inject drugs in Bristol, UK: an economic evaluation. Addiction 2020;115(4):702–13.

[50] For more details see https://hri.global/wp-content/uploads/2021/11/HRI_Integrated_Services_Briefing-2021.pdf.

other health and social services, such as primary care, sexual and reproductive health services, legal aid, housing support, and more. In doing so, they ensure that a wide range of services are available and accessible to their clients, making them highly effective and cost-effective.

For example in South Africa, a non-profit primary healthcare facility has designed and evaluated a decentralised, simplified, complete point-of-service model to screen and link people who inject drugs to HIV and HCV care.[51] The programme provided harm reduction services (including OAT and harm reduction packs) alongside adherence support in the form of directly observed HCV therapy and peer support. Weekly financial allowances were offered to people receiving the service to reimburse transport costs and their time. Out of the 67% of people who tested HCV-antibody positive, 81% were assessed as eligible for therapy, and 93% of those eligible initiated it.[52] This programme shows that a decentralised, person-centered harm reduction strategy can bridge gaps in treatment access for people who use drugs.[53] However, to ensure the effectiveness of such interventions, community- and peer-led outreach campaigns, with collaborative treatment support and referrals, are needed alongside sustained, unrestricted access to harm reduction services, such as OAT, to decrease the risk of reinfection.

In recent times, innovative harm reduction approaches for **chemsex** have been monitored. One particularly relevant example is that of Digital Outreach and Online Harm Reduction Services; whereby Online platforms and mobile apps are being used to provide information on safer drug use, HIV prevention, and harm reduction strategies. Some examples include the TestBKK[54] initiative in Thailand, which provides online guidance on safe chemsex practices and allows users to order prevention packages that include condoms, lubricants, HIV prevention resources, and free blood test.[55] Similarly in Taiwan, Min-Sheng Hospital in Kaoshiung City supports the HERO (Healing, Empowerment, Recovery of chemsex) clinic, which uses an integrated health service model to create a one-stop health and social service designed to address the needs of gay men and other men who have sex with men who engage in chemsex. The clinic reportedly uses digital technologies to make the service easy to access, and centralises the diagnosis, treatment and prevention of STIs and mental health issues, including access to counselling and specialist care with an emphasis on tailoring care according to an individual's self-assessed needs.[56]

Another virtuous example is that of Lighthouse, a Hanoi-based organisation that caters specifically to gay, bisexual and other men who have sex with men, with a strong focus on community engagement. In addition to providing accessible peer support, harm reduction

[51] Saayman, E., V. Hechter, N. Kayuni and M. Sonderup, (2023), 'A simplified point-of-service model for hepatitis C in people who inject drugs in South Africa', Harm Reduction Journal, vol. 20. no. 1, p.27
[52] Ibid.
[53] Ibid.
[54] https://www.testbkk.org/en/
[55] HRI (2021), Chemsex and harm reduction for gay men and other men who have sex with men, p.8. https://hri.global/publications/chemsex-and-harm-reduction-for-gay-men-and-other-men-who-have-sex-with-men/
[56] HRI, Global State of Harm Reduction 2022, p. 56.

packages, sexually transmitted infection (STI) prevention services such as pre-exposure prophylaxis (PrEP) and specialist referrals, the organisation's advisory board consists of gay men and other men who have sex with men. By taking this community-centred approach, the organisation is able to ensure that its efforts reflect the realities of the communities it supports.[57]

Another important innovation that requires urgent scale-up is **drug consumption rooms**[58]: Drug consumption rooms (DCRs) integrate harm reduction with HIV services, offering supervised drug use alongside testing, care, and referral pathways. Mobile, hospital-based, and housing-integrated DCRs extend services to hard-to-reach groups and improve service uptake.

During the global pandemic for COVID-19, some harm reduction services proved to be resilient and adapted to meet the new need of people who use drugs. Many countries eased OAT regulations and there were substantial moves towards take-home OAT. That is the case in the UK, where most people were moved onto 7 to 14 days prescription instead of daily or supervised intake. In Aotearoa-New Zealand, take-home naloxone and take-home OAT doses were rolled out for the first time following lockdown. Similarly, in Australia, after the experience lived during the pandemic, a four-year programme of take-home naloxone was initiated. The pandemic also created opportunity for increased digitisation of harm reduction services in the region thanks to the quick response of peer-led organisations that rapidly adapted to online delivery of education tools and distribution of sterile injecting equipment via post. These innovations not only increased accessibility during the pandemic but also contribute to reach people in rural and remote areas and remove some barriers that people who use drugs routinely face while accessing services improving the overall experience.

(h) How can HIV responses address intersectional issues, including those experienced by key populations, and women and girls. Please indicate concrete measures taken.

Harm reduction intervention addresses intersectional issues of people who use and inject drugs. Drug use is compounded by various issues such as social stigma and discrimination, racial injustice, family relationship, health (infection, mental health), education, employment and so on.

Young people who inject drugs are 50% more likely to acquire HIV and hepatitis C than adults. Despite this elevated risk, most harm reduction services remain focused on adults, often overlooking the unique needs of adolescents and young people. The failure to address this gap in service provision leaves young drug users vulnerable to acquiring serious infections,

[57] HRI,(2022) The Global State Of Harm Reduction 2022. Chemsex in Asia, p.56.
[58] HRI (2025) Drug consumption rooms: service models and evidence. https://hri.global/publications/drug-consumption-rooms-service-models-and-evidence/

such as HIV and hepatitis C, while missing out on the appropriate support and resources they require to protect their health and well-being.[59,60]

LGBTQI+ youth, particularly transgender people, face discrimination and violence both within their communities and from healthcare providers. In countries such as Russia and Uganda, young LGBTQI+ people often face significant barriers in accessing harm reduction services. These individuals experience violence and discrimination both within their communities and from healthcare providers, creating an environment of fear and alienation. This fear of mistreatment or rejection often leads them to avoid seeking the healthcare they need, further exacerbating their vulnerability to health issues like HIV and substance use.[61]

Youth-friendly harm reduction services are more effective when young people are involved as peer educators and co-designers of services. By involving young people in the development and delivery of harm reduction services, these programs become more tailored to the specific needs and concerns of adolescents and young adults. Peer educators can relate to their peers' experiences, creating an environment of trust and understanding that is crucial for effective health interventions. Empowering young people to co-design services ensures that they are more likely to engage with the programs and utilize the available resources.

On the other hands, expanding health and social services to rural and underserved areas is essential for young people, who are often the most marginalized and underserved group in these regions. Young people in rural and underserved areas face significant barriers to accessing healthcare and support services, including a lack of transportation, fewer healthcare providers, and limited awareness of available services. This makes them more vulnerable to health issues such as substance abuse, HIV, and mental health problems. Expanding services to these areas is vital to ensure that young people receive the care and support they need to lead healthy, productive lives.

Gender-based violence and HIV/AIDS are interconnected crises that demand urgent action. In 2023, 570 young women and girls aged 15–24 acquired HIV every day, with women in this age group living in at least 22 countries in Eastern and Southern Africa being three times more likely to live with HIV than their male peers.[62] This stark disparity highlights the urgency of addressing the interconnectedness of gender-based violence and HIV/AIDS, as tackling one issue without addressing the other will only exacerbate the crisis. Structural inequalities and violence must be confronted to effectively combat both.

This dual problem of gender-based violence and HIV/AIDS cannot be effectively addressed without tackling the structural inequalities and violence that perpetuate it. The intersection of

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[59] Artenie, A., et al., (2023), 'Incidence of HIV and hepatitis C virus among people who inject drugs, and associations with age and sex or gender: a global systematic review and meta-analysis', Lancet Gastroenterology and Hepatology, vol. 8, no. 6, p.533-552.

[60] HRI, (2024) Global State of Harm Reduction 2024, Youth Chapter. p.94.

[61] HRI, (2024) *Global State of Harm Reduction 2024*, Youth Chapter. P.99-100.

[62] UNAIDS, (2024), UNAIDS report shows that upholding human rights is vital for ending the AIDS pandemic.
https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2024/november/20241126_world-aids-day-report

gender-based violence and the HIV epidemic is a deeply rooted issue, where women and girls are disproportionately affected. To create lasting change, it is essential to dismantle the social, economic, and political structures that perpetuate violence against women and girls and contribute to the spread of HIV. A comprehensive approach that addresses both root causes is necessary to reduce both violence and new HIV infections.

Women and girls often face additional discrimination, especially in environments like prisons, which are designed primarily for male users. In these settings, the needs of women and girls who are incarcerated are frequently overlooked or inadequately addressed. Gender-specific healthcare, including reproductive health services and support for victims of gender-based violence, is often lacking, further exacerbating the vulnerability of women in such environments. It is critical that prisons and correctional facilities adapt to meet the unique needs of incarcerated women and girls, ensuring that they are treated with dignity and respect.

Trans people, sex workers, and LGBTQI+ individuals are often excluded from healthcare due to legal and institutional discrimination. For many, healthcare is often inaccessible due to systemic discrimination, both in terms of the laws that govern their rights and the bias they experience within medical institutions. This exclusion leads to poorer health outcomes and greater vulnerability to conditions like HIV, hepatitis C, and mental health issues. It is essential to challenge these discriminatory practices and ensure that all individuals, regardless of their gender identity or sexual orientation, have equal access to necessary healthcare.

For these underserved populations, integrated and person-centred services are key. Integrated and person-centred services that involve peer leadership help build trusting relationships and ensure that people are treated as human beings, not just clients. Peer leadership is a key component of effective harm reduction and healthcare services. When peers lead programmes, they foster trust and create an environment where individuals feel respected and valued. Evidence shows that peer involvement in HIV and harm reduction services is linked to better health outcomes, including reduced incidence of HIV, increased accessibility, better service quality, reduced risk behaviors, and a reduction in stigma and discrimination. Peer involvement is a crucial element of successful HIV prevention and harm reduction programmes.

Additionally, integrating services ensures that individuals can access a wide range of healthcare and social services in a seamless and supportive environment. It also makes them easier for clients to navigate, providing more efficient support and addressing the various barriers they face when accessing external services. Navigating multiple, siloed services can be confusing and overwhelming for clients, particularly those with complex needs. By integrating services, healthcare providers can offer a more streamlined and efficient experience, ensuring that clients receive the comprehensive care they need without unnecessary obstacles. This integration also helps to identify and address barriers that may have previously hindered access to essential services.

Lastly, integrated services understand the unique challenges that the community face and ensure they are referred to the most appropriate options for their needs.

(i) What partnerships, coordination or collaborations have been most effective in ensuring lasting impacts of HIV response strategies? Please provide concrete examples.

The tangible collaborations between government, donors, civil society and communities, with financial implications, have had lasting impact of HIV response strategies. In Tswane, South Africa, the municipal government teamed up with civil society and communities to start up the comprehensive harm reduction program called Community Oriented Substance Use Program (COSUP). COSUP is funded by the municipal government and later PEPFAR contributed to the funding. COSUP operates on social contracting model where the government channels funding to University of Pretoria for the fund management, civil society and community group advise and implement the programs. HRI study found that COSUP program was cost effective as compared to donor funded program, described as the most positive example of the scale-up of harm reduction services in South Africa during the COVID-19 lockdown, tangible health outcome (high retention on opioid agonistic therapy, perceived improved client's health etc) and the program has received continuous funding since 2016. The recent US funding pause and terminations had impact on the programme but it was relatively lesser as compared to other US funded district in South Africa.

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

In current situation where key populations remains criminalised, stigmatised and discriminated against, the following actions are at-most important to be undertaken:

1. Decriminalise possession and drug use; and further repeal punitive and discriminative laws against people who use drugs.
2. Divest from the unjust drug war and related punitive drug law enforcement at the international, national, and subnational levels, and invest in programmes that prioritise community, health and justice.
3. Ensure uninterrupted access to life saving harm reduction and HIV services and commodities
4. Support initiative and increase funding for community-based organisations and civil societies to continue to monitor and advocate for the realisation of human rights of people who use drugs