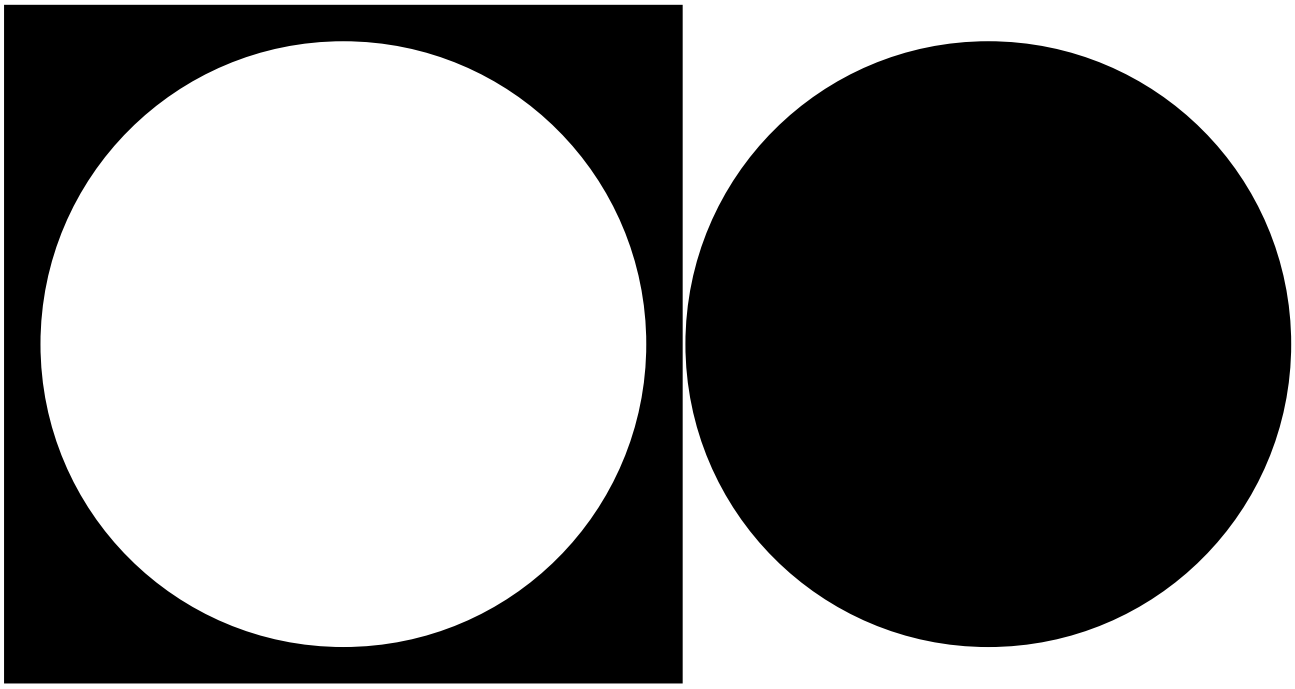


GLOBAL OVERVIEW 2025

THE GLOBAL STATE OF HARM REDUCTION:
2025 UPDATE TO KEY DATA

HARM REDUCTION INTERNATIONAL

This briefing provides updates to key data from *The Global State of Harm Reduction*, our flagship biennial report. The full report is published every two years, with updates to key data in between editions of the report. This update also summarises key developments in harm reduction services, funding and drug policy since the launch of the ninth edition of the report in November 2024.

HARM REDUCTION INTERNATIONAL

TABLE 1 COUNTRIES OR TERRITORIES EMPLOYING A HARM REDUCTION APPROACH IN POLICY OR PRACTICE

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
ASIA										
Bangladesh	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Bhutan	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Brunei Darussalam	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Cambodia	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
China	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Hong Kong	✗	✗	✓	nd	✗	✗	✗	✗	✗	✗
India	✓	✓	✓	nd	nd	nd	✓	✗	✗	✓
Indonesia	✓	✓	✓	nd	✗	✗	✓	✗	✗	✓
Japan	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Laos	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Macau	✓	✓	✓	nd	✗	✗	✗	✗	✗	✓
Malaysia	✓	✓	✓	nd	✗	✗	✗	✗	✗	✓
Maldives	✓	✗	✓	nd	✗	✗	✗	✗	✗	✗
Mongolia	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Myanmar	✓	✓	✓	nd	✓	✓	✗	✗	✗	✗
Nepal	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
North Korea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Philippines	✓	✗	✗	nd	✗	✗	✗	✗	✗	✗
Singapore	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
South Korea	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Sri Lanka	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Taiwan	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Thailand	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Vietnam	✓	✓	✓	nd	✗	✗	✗	✗	✗	✓
EASTERN AND SOUTHERN AFRICA										
Angola	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Botswana	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Comoros	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Eritrea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Eswatini	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ethiopia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Kenya	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Lesotho	✗	✗	✗	nd	nd	nd	nd	nd	nd	nd
Madagascar	✗	✗	✗	nd	nd	nd	nd	nd	nd	nd
Malawi	✓	✗	✗	✗	✗	✗	✗	nd	✗	✗

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Mauritius	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Mozambique	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Namibia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Rwanda	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Seychelles	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
South Africa	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗
South Sudan	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Uganda	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
United Republic of Tanzania	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Zambia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Zimbabwe	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
EURASIA										
Albania	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Armenia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Azerbaijan	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗
Belarus	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bosnia and Herzegovina	✓	✗	✓	✗	✗	✗	✗	✗	✗	✓
Bulgaria	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗
Croatia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Czechia	✓	✓	✓	✗	✓	✗	✓	✓	✗	✓
Estonia	✓	✓	✓	✗	✓	✗	✓	✗	✗	✓
Georgia	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Hungary	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Kazakhstan	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Kosovo	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Kyrgyzstan	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Latvia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Lithuania	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Moldova	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓
Montenegro	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
North Macedonia	✓	✓	✓	✗	✗	✗	✗	✗	✓	✓
Poland	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Romania	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Russia	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗
Serbia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Slovakia	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗

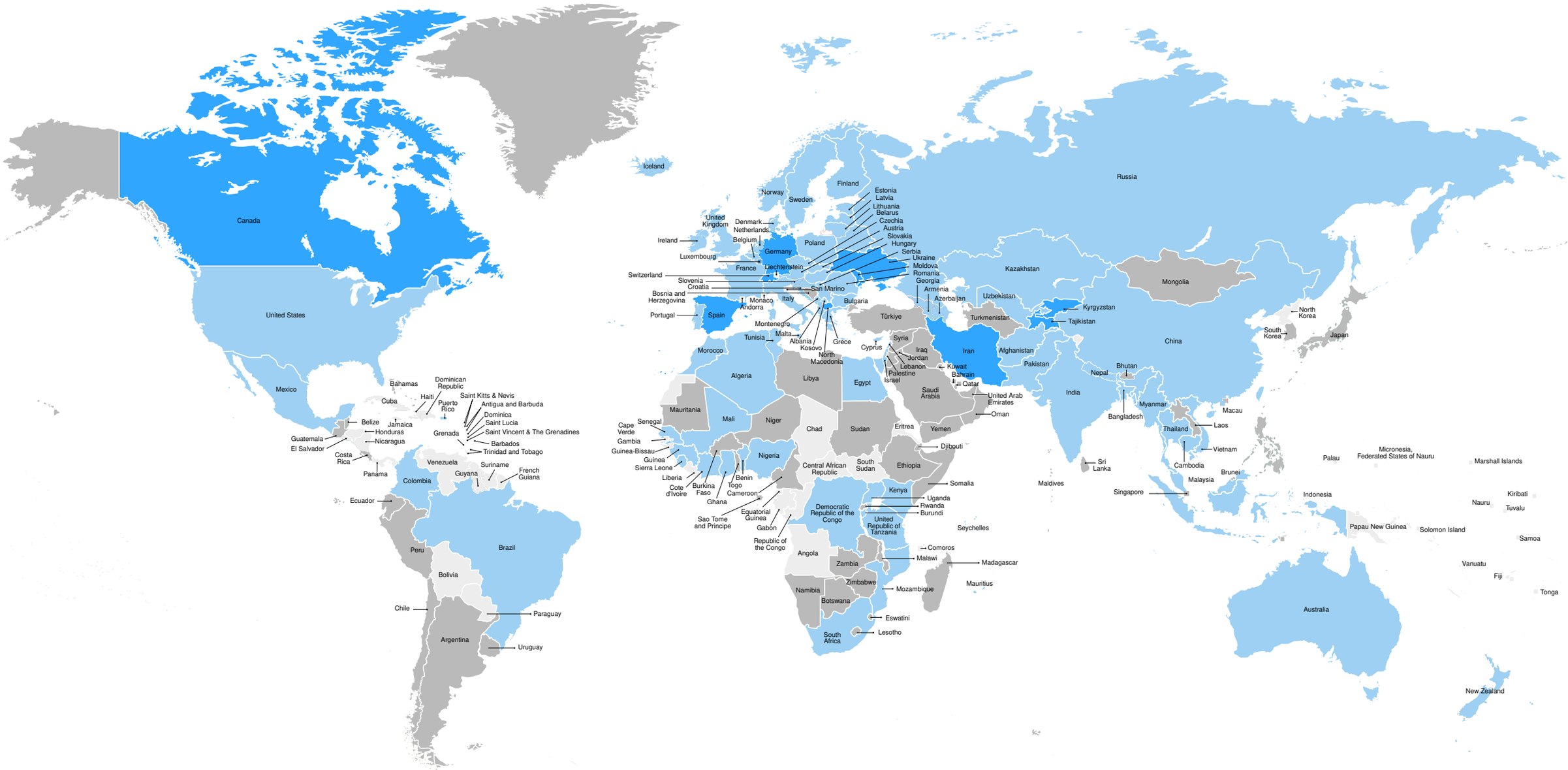
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Slovenia	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Tajikistan	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Turkmenistan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ukraine	✓	✓	✓	✗	✓	✗	✗	✓	✓	✓
Uzbekistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
LATIN AMERICA AND THE CARIBBEAN										
Antigua and Barbuda	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Argentina	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Bahamas	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Barbados	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Belize	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Bolivia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Brazil	✓	✓	✗	✗	✗	✗	✓	✗	✗	✗
Chile	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Colombia	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗
Costa Rica	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cuba	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Dominican Republic	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Dominica	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Ecuador	nd	✗	✗	✗	✗	✗	✗	nd	✗	✗
El Salvador	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Grenada	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Guatemala	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guyana	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Haiti	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Honduras	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Jamaica	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Mexico	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗
Nicaragua	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Panama	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Paraguay	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Peru	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
Puerto Rico	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Saint Kitts and Nevis	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Saint Lucia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Saint Vincent and the Grenadines	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Suriname	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Trinidad and Tobago	✓	nd	nd	nd	nd	nd	nd	nd	nd	nd
Uruguay	✓	✗	nd	✗	✗	✗	✗	✗	✗	✗
Venezuela	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
MIDDLE EAST AND NORTH AFRICA										
Afghanistan	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Algeria	✓	✓	✓	nd	✗	nd	✗	✗	✗	✓
Bahrain	nd	✗	nd	✗	✗	✗	✗	✗	✗	✗
Djibouti	nd	✗	nd	✗	✗	✗	✗	✗	✗	✗
Egypt	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Iran	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Iraq	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Israel	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Jordan	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Kuwait	nd	✗	✓	✗	✗	✗	✗	✗	✗	✗
Lebanon	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Libya	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Morocco	✓	✓	✓	✗	✗	✗	✓	✗	✗	✓
Oman	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Pakistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Palestine	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Qatar	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Saudi Arabia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Somalia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Sudan	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Syria	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Tunisia	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
United Arab Emirates	nd	✗	✓	✗	✗	✗	✗	✗	✗	✗
Yemen	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
NORTH AMERICA										
Canada	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
United States of America	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓

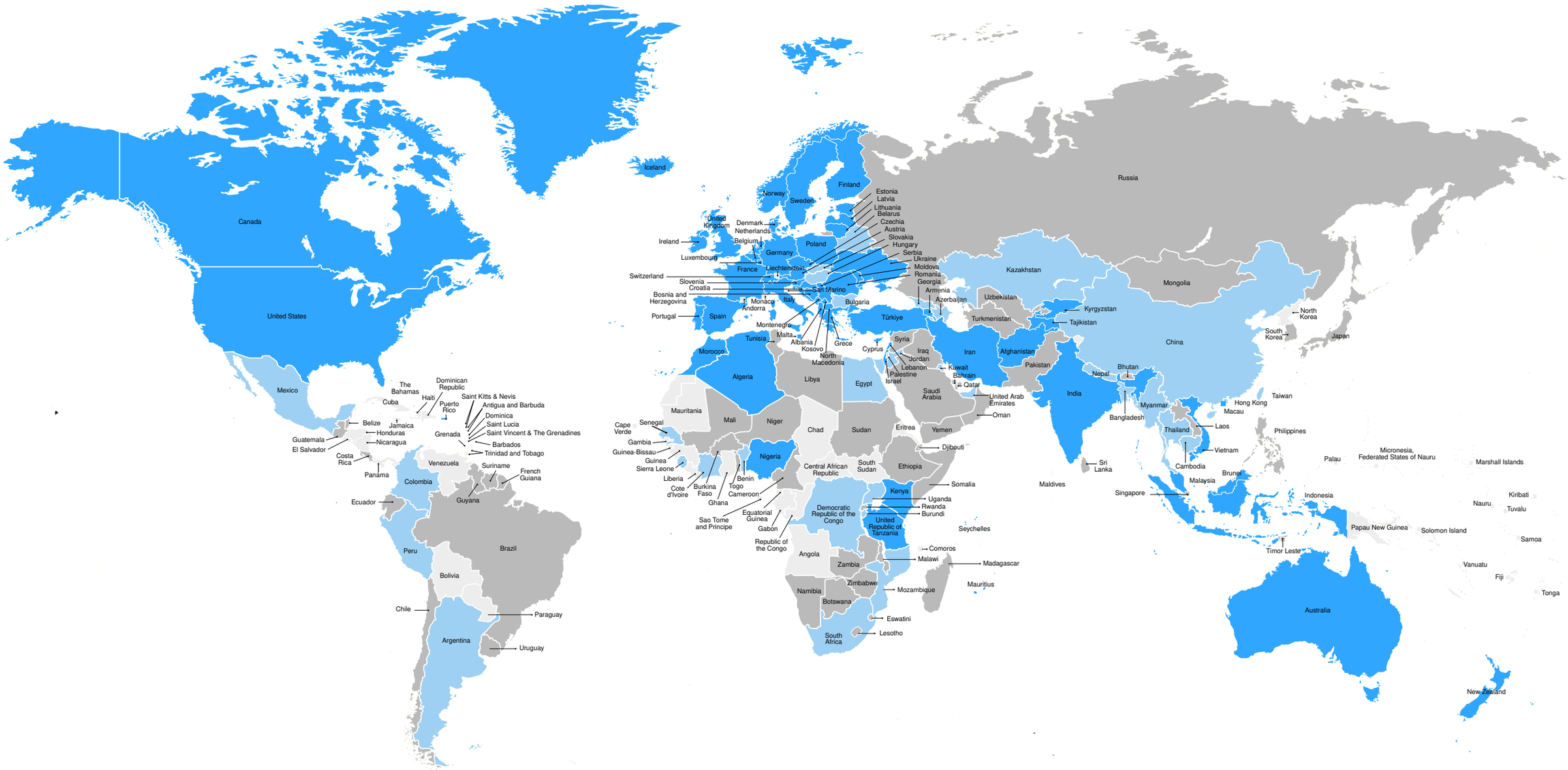
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
OCEANIA										
Aotearoa New Zealand	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Australia	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓
Federated States of Micronesia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Fiji	✓	nd	nd	nd	nd	nd	nd	nd	nd	nd
Kiribati	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Marshall Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Nauru	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Palau	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Papua New Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Samoa	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Solomon Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Timor Leste	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tonga	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tuvalu	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Vanuatu	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
WEST AND CENTRAL AFRICA										
Benin	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Burkina Faso	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Burundi	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Cameroon	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cape Verde	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Central African Republic	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Chad	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Congo	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Côte d'Ivoire	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Democratic Republic of the Congo	✓	✓	✓	nd	nd	nd	nd	nd	nd	nd
Equatorial Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Gabon	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Gambia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Ghana	✓	✓	nd	nd	nd	nd	nd	nd	nd	nd
Guinea	✓	✓	nd	nd	nd	nd	nd	nd	nd	nd
Guinea-Bissau	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Liberia	✓	nd	nd	nd	nd	nd	nd	nd	nd	nd

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Mali	✓	✓	✗	nd	nd	nd	nd	nd	nd	nd
Mauritania	✗	✗	nd	nd	nd	nd	nd	nd	nd	nd
Niger	✗	✗	nd	nd	nd	nd	nd	nd	nd	nd
Nigeria	✓	✓	✓	nd	✗	✓	nd	nd	nd	✓
Sao Tome and Principe	✓	✗	nd	nd	nd	nd	nd	nd	nd	nd
Senegal	✓	✓	✓	nd	nd	nd	nd	nd	nd	nd
Sierra Leone	✓	✓	✓	✓	nd	nd	nd	nd	nd	nd
Togo	✓	✗	✗	nd	nd	nd	nd	nd	nd	nd
WESTERN EUROPE										
Andorra	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Austria	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Belgium	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Cyprus	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Denmark	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Finland	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
France	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓
Germany	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Greece	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Iceland	✓	✓	✓	✓	nd	nd	nd	✗	✗	✓
Ireland	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Italy	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Liechtenstein	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Luxembourg	✓	✓	✓	✓	✗	nd	nd	✗	✓	✓
Malta	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Norway	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Portugal	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓
San Marino	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Sweden	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Switzerland	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓
Türkiye	✗	✗	✓	✗	✗	✗	nd	✗	✗	✓
United Kingdom	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓
GLOBAL TOTAL	**112**	**93**	**95**	**19**	**35**	**24**	**26**	**6**	**11**	**61**

M1.1 GLOBAL AVAILABILITY OF NEEDLE AND SYRINGE PROGRAMMES (NSPs) IN THE COMMUNITY AND IN PRISON



M1.2 GLOBAL AVAILABILITY OF OPIOID AGONIST THERAPY (OAT) IN THE COMMUNITY AND IN PRISON



- OAT available in the community
- OAT available in the community and prison
- OAT not available
- No data

KEY GLOBAL DEVELOPMENTS SINCE NOVEMBER 2024

- The number of countries with explicit supportive references to harm reduction in national policy documents has increased from 108 to 112. Newly reported countries include Ghana, Fiji, Trinidad & Tobago, and the Philippines.
- In Nigeria, opioid agonist therapy (OAT) programmes have been introduced, bringing the global total of countries where at least one OAT programme operates to **95**.
- The United Kingdom's first drug consumption room (DCR) opened in Glasgow, Scotland, named "The Thistle", raising the number of countries operating DCRs to **19**.
- In India, pilot take-home naloxone programmes launched for community-based distribution in Punjab, Manipur and Mizoram.
- At least one naloxone peer distribution programme is now operational in Nigeria.
- There is currently at least one active programme in Morocco that distributes safer smoking kits, making the global tally of **26** countries offering safer smoking kits.

Based on available data, no country has reported a complete cessation of needle and syringe programmes (NSP), opioid agonist therapy (OAT), drug consumption rooms (DCRs), naloxone distribution, safer smoking kit programmes, or stimulant prescription initiatives since 2024. Yet, the global harm reduction landscape has become increasingly fragile. Funding cuts and policy uncertainty have reduced service coverage, closed sites, and negatively affected frontline HIV and harm reduction staff. This threatens decades of progress in public health and human rights for people who use drugs.

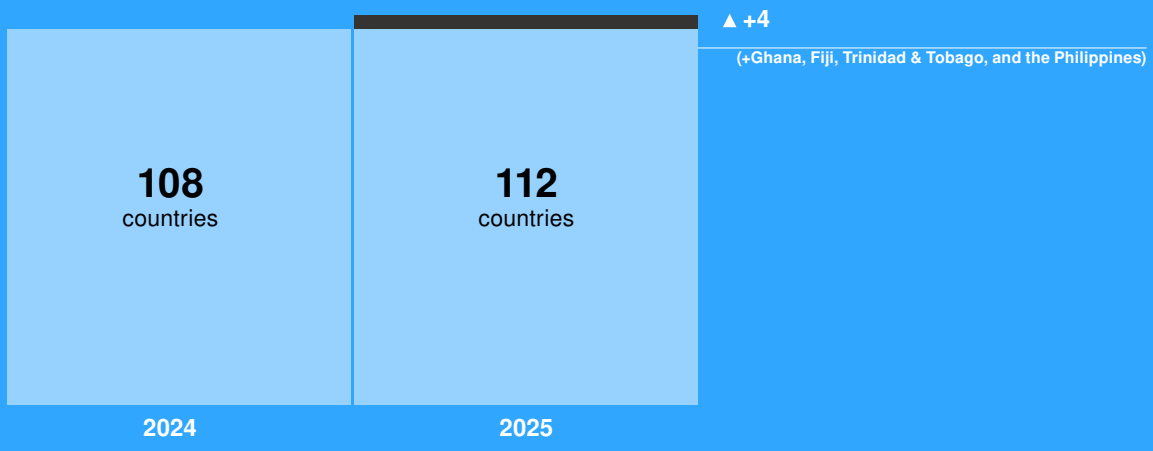
In January 2025, the United States Government suspended its bilateral and multilateral, including its support for harm reduction and related health initiatives. Although a portion of funding was later reinstated, most support has been halted indefinitely. Prior to the cuts, the United States was the second-largest global source of donor funding for harm reduction and the largest contributor to the Global Fund. The sudden withdrawal created immediate uncertainty, particularly in countries lacking domestic funding, placing the sustainability of global harm reduction efforts under severe strain.

Across many regions, funding reductions have led to site closures and disrupted outreach. Despite these challenges, community-led organisations and networks have shown extraordinary resilience, sustaining essential interventions through innovation and solidarity. From peer-led naloxone distribution to informal outreach models, these efforts have preserved life-saving services for people who use drugs. However, without structured and sustained financing, community-led innovation alone cannot provide the systemic infrastructure required for comprehensive harm reduction at the scale that is needed.

Amid this situation, the Global Fund and the World Health Organization reaffirmed harm reduction as an essential health intervention. Nevertheless, harm reduction in low- and middle-income countries remains heavily reliant on external donor financing, leaving it vulnerable to global political changes. Strengthening domestic investment and integration into national health systems is now essential to ensure the continuity of services and the protection of public health gains.

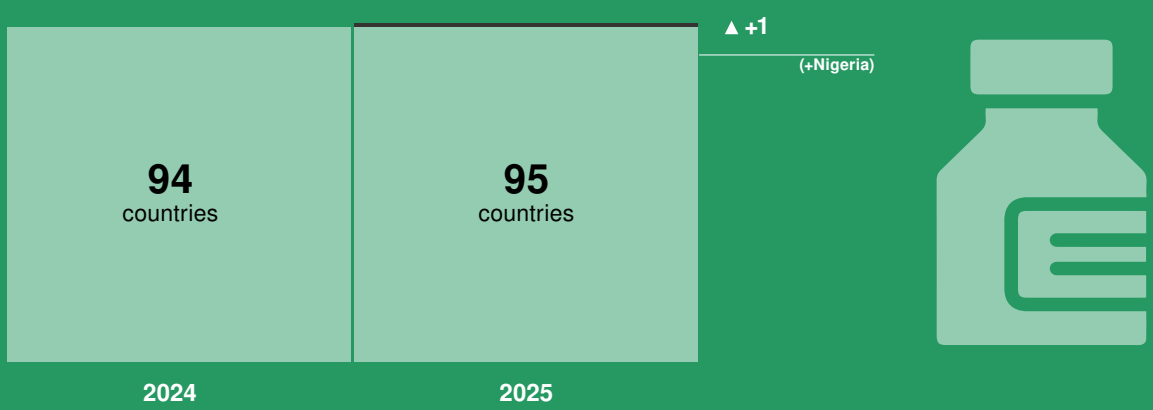
GLOBAL AVAILABILITY OF HARM REDUCTION INTERVENTIONS FROM 2024 TO 2025

EXPLICIT SUPPORTIVE REFERENCES TO HARM REDUCTION IN NATIONAL POLICY DOCUMENTS



OPIOID AGONIST THERAPY (OAT)

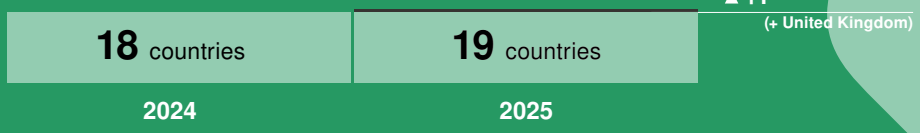
95 countries with at least one OAT programme in 2025



GLOBAL AVAILABILITY OF HARM REDUCTION INTERVENTIONS FROM 2024 TO 2025

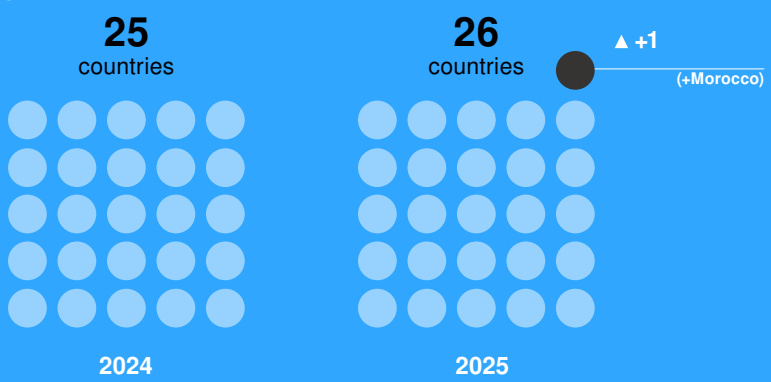
DRUG CONSUMPTION ROOMS (DCRS)

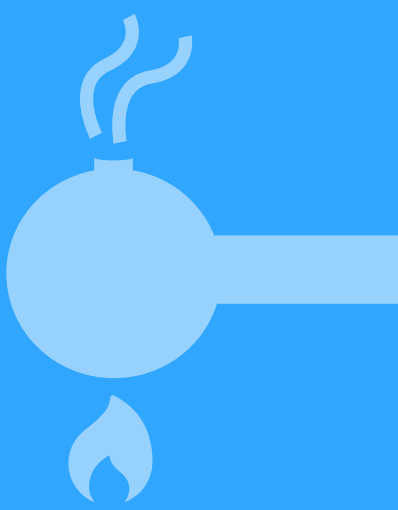
19 countries with operational DCRs in 2025



SAFER SMOKING EQUIPMENT

26 countries with at least one safer smoking kit distribution programme





Country-level developments showing progress and setbacks across regions

Developments in 2025 reflect a complex and often contradictory global harm reduction landscape, where progress and setbacks coexist, sometimes even within the same country or region.

- Colombia's second drug consumption room opened in Cali. The country also hosted the Harm Reduction International Conference (HR25) in Bogotá, welcoming over 1,000 participants from more than 60 countries to discuss, collaborate and critically reflect around the theme Sowing Change to Harvest Justice.
- In Mexico, the national government has reinforced prohibitionist approaches, launching a highly visible campaign against fentanyl grounded in fear and stigma, and cutting public funding for health programs, including HIV-related care. At the same time, the local Mexico City administration has taken a different path. In August 2025, it created designated cannabis consumption zones with public support services.
- Australia presents a similarly mixed picture. Drug-checking services were introduced in New South Wales, and there are plans to expand to Victoria, marking a significant advance in evidence-based policy. Meanwhile, Queensland withdrew funding for drug-checking services and became the first Australian state to ban drug-checking.
- In Georgia, the government forced the closure of all commercial OAT programmes, transferring clients to state-run services and announcing plans to relocate all OAT sites serving around 15,000 patients to remote facilities, raising concerns about access and the quality of care.
- In the United States, on top of international cuts to harm reduction funding, the Trump Administration issued an Executive Order in July 2025 that threatened domestic funding cuts and even civil and criminal penalties against harm reduction services. This in effect reverses previous federal commitments to harm reduction. However, the US National HIV/AIDS Strategy, which includes supportive references to harm reduction, is set to expire at the end of 2025. The *Global State of Harm Reduction* continues to classify the United States as a country with explicit supportive references to harm reduction in national policy documents, although this stance is now severely undermined by the Executive Order.

These developments highlight that while harm reduction continues to advance overall, in many places its coverage and scale remain limited, and in some contexts, it is newly under threat. Significant inequalities persist both within and between regions and countries in terms of availability and access. Progress also remains vulnerable to political shifts and funding constraints.

HARM REDUCTION FUNDING DEVELOPMENTS

The global health funding landscape has undergone profound upheaval in 2025, with grave consequences for harm reduction. The sustainability of harm reduction programming in many countries is now under serious threat. Harm Reduction International research conducted in September 2025 found that almost 92% of respondents deemed harm reduction to be under threat in their country, with 62% describing the threat as high or critical[a]. Many governments continue to prioritise spending vast amounts on punitive drug policies over investing in policies rooted in health.

Even before the latest disruptions, harm reduction was chronically underfunded. In 2022, harm reduction funding was just 6% of the overall need in low- and middle-income countries. That year, out of USD 22.4 billion spent on the HIV response, only 0.7% went to harm reduction, despite 8% of new HIV infections occurring among people who inject drugs. Developments in 2025 have only widened this funding gap.

a The Global State of Harm Reduction 2025 survey gathered 56 responses from individuals across 23 countries to inform this update.

Abrupt halt of US Government aid

In January 2025, the United States Government abruptly halted its bilateral and multilateral aid. While some funding was later restored after initial stop-work orders, a large majority of funding was stopped indefinitely. The United States had been the second largest harm reduction donor (after the Global Fund) and the largest contributor overall to the Global Fund portfolio. The sudden funding cuts sent shockwaves through low- and middle-income countries reliant on this support, especially those without domestic harm reduction budgets. As the United States was also the largest contributor to the Global Fund, this triggered a reprioritisation process that reduced country allocations and halted scale-up plans for Grant Cycle 7.

Country-level consequences

The impact has been immediate and far-reaching. In countries receiving direct funding from PEPFAR or other United States agencies, many harm reduction services closed overnight, or were forced to operate at significantly reduced capacity, with community-led services hardest hit. Kenya has witnessed closure of at least one NSP site (Nairobi Outreach Services Trust-NOSET) and the largest OAT centre (Mathari Methadone Facility). Although nine OAT sites remain, their operational capacity is significantly reduced. Closure of some OAT programmes and NSP sites was also reported in Tajikistan. In Nigeria the planned expansion of NSP sites in additional states was halted. Similarly, two OAT sites in South Africa closed, cutting off methadone for almost 5,000 clients, while several NSP sites reduced operations. In Tshwane, a single municipal government-funded programme, COSUP, absorbed nearly half of the national harm reduction services during the crisis, leading to overstretch and staff burnout. Uganda has been left with only one operational OAT and NSP site, following the shutdown of the Kampala Region HIV Project and the Butabika MAT clinic. In other countries, there are reports of services surviving by reducing their operations such as in Cambodia, Mozambique and Tanzania.

The human impact

The loss of skilled human resources – including peer educators, outreach workers and counsellors – has cut people who use drugs off from essential services. These roles are crucial for maintaining trust, providing health information, and connecting people to care. Other losses in supportive roles for harm reduction programmes have been reported. For example, donor-funded data management personnel in Kenya, resulting in inconsistent data entry, delayed submission of reports and gaps in monitoring key performance indicators across sites.

Modelling suggests that an additional 3,739 new HIV infections and 6,770 new HCV infections could occur over the next year due to the combined impact of disruptions in OAT and NSP, equating to an 8.3% and 7.9% increase in HIV and HCV incidence among people who inject drugs respectively[b].

Global Fund reprioritisation and harm reduction

In response to the funding crisis provoked by the United States Government, the Global Fund prioritised the continuity of existing life-saving services. While this protected some harm reduction services, the planned roll-out of new harm reduction services halted in several countries, including Ghana, Nepal, Nigeria and South Africa, as allocated resources were redirected to those already operating. Where services were maintained, new enrolment stalled, leaving progress stagnating. Activities deemed to be 'non-life saving' (such as advocacy, outreach, peer education, capacity development and organisational costs) have reduced

b Mutai KK, et.al (in review) Modelling the potential impact of the suspension of US PEPFAR funding for opioid agonist therapy and needle and syringe programmes on HIV and Hepatitis C transmission among people who inject drugs.

significantly or stopped entirely. Even where major harm reduction services remained uninterrupted due to domestic funding, such as in Mauritius and Indonesia, these broader supportive activities have been affected.

The wider impact of the funding crisis

Wider HIV prevention and treatment services have also been impacted, with reduced service and outreach capacity. Access to HIV testing, treatment and pre-exposure prophylaxis (PrEP) have been severely affected, putting the UNAIDS 95-95-95 targets to end AIDS as a public health threat by 2030[c] in even further jeopardy.

Alongside the dismantling of the United States' aid programme, there have been reductions in development assistance from several other donor countries. This has negatively impacted the Robert Carr Fund, a crucial source of funds for global and regional community-led and civil society advocacy, as well as multilateral agencies which play functions crucial to harm reduction around the world. A streamlined WHO and reduced UNAIDS joint programme pose great risk to the future of harm reduction. Now more than ever, we need strong community-led and civil society advocacy and a multilateral system that can lead, protect and promote harm reduction and champion evidence-based, rights-based policies and programmes for people who use drugs.

Reports of resilience

Importantly, the effects of the 2025 events have not been felt equally across countries. Those with established domestic funding for harm reduction services have shown the greatest resilience, shielding programmes and communities from the worst of the crisis. For instance, municipal harm reduction programmes in South Africa continued under additional strain but without interruption; civil society in Indonesia reported lesser impacts due to the integration of harm reduction into primary health care; and in Mauritius and Moldova, for example, harm reduction services such as NSP and OAT continued relatively uninterrupted due to domestic government funding. Moldova even piloted a government-funded OAT vending machine in 2024, with plans to scale up to eight more vending machines.

Reports indicate that in some cases remaining programmes have consolidated resources, combining services where possible, such as by integrating drop-in centre services with OAT sites or sharing excess PrEP stocks with other sites in need. While reducing overall coverage, this approach ensured the continuity of service provision in difficult circumstances.

Some governments stepped up with commitments and allocations to cover funding gaps for HIV treatment, such as in South Africa and Nigeria. However, promises to support harm reduction have yet to materialise. While efforts to secure government support are ongoing, no tangible progress has been reported from our survey respondents. In some countries, for example, Mozambique and South Africa, the Global Fund and other donors including the Gates Foundation and ViiV Healthcare have provided some support to sustain services affected by the United States funding cuts.

Communities, as ever, have proven resilient and determined in the face of funding challenges. Peer networks have stepped in where formal systems have faltered, ensuring people know where and how to access life-saving services. Yet this resilience should not be mistaken for sustainability. Community-led organisations are doing extraordinary work with minimal support, but without dedicated and consistent funding, their ability to protect health and save lives is at risk.

c The 95-95-95 targets: 95% of people living with HIV (PLHIV) will know their status, 95% of those who know their status will be on sustained antiretroviral therapy (ART), and 95% of those on ART will achieve viral suppression by 2030.

Importance of budget advocacy

At a time when governments are faced with shortfalls, forced to scrutinise and reorganise their spending, budget advocacy is crucial to ensure they have the evidence required to make effective and cost-effective investments, including in harm reduction. But funding for civil society and community-led advocacy, technical support and capacity building has also been squeezed. Supporting this work is essential to turn mitigation measures and government pledges into action, not just words.

TABLE 2 IMPACT OF FUNDING CUTS ON HARM REDUCTION SERVICE SITES

Services reduced · Services closures · Minimal impact

KENYA

Impact on OAT: Impact on NSP:

OAT services in particular relied heavily on US government (PEPFAR) funding, and at least one was forced to suspend operations. NOSET NSP also stopped operating due to cuts.

NEPAL

Impact on OAT: Impact on NSP:

Global Fund reprioritisation has forced many harm reduction sites to close.

TAJIKISTAN

Impact on OAT: Impact on NSP:

In a country where 80% of HIV funding is external, US government cuts to CDC/PEPFAR funding forced at least three harm reduction centres suspend services.

UGANDA

Impact on OAT: Impact on NSP:

One of the country's two OAT sites closed due to US government cuts. NSPs are facing shortages of commodities.

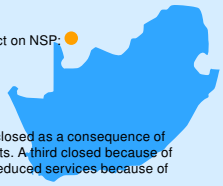
UKRAINE

Impact on OAT: Impact on NSP:

The ongoing war has led to the closure of harm reduction services, and new Ministry of Health policies on data collection have reduced accessibility. NSPs have reduced services because of international funding cuts.

SOUTH AFRICA

Impact on OAT: Impact on NSP:



A quarter (2) of OAT sites closed as a consequence of US government funding cuts. A third closed because of non-US cuts. NSPs have reduced services because of international cuts.

NIGERIA

Impact on OAT: Impact on NSP:

Cuts to PEPFAR ended NSP provision in at least three states (Akwa Ibom, Cross River and Rivers).

CAMBODIA

Impact on OAT: Impact on NSP:

US Government funding cuts have forced a refocussing on priority interventions with some impacts on NSP and OAT sites.

MOZAMBIQUE

Impact on OAT: Impact on NSP:

US government funding cuts have forced a reduction in services at the country's only harm reduction site, though the Global Fund has supported the continuation of OAT and NSP.

TANZANIA

Impact on OAT: Impact on NSP:

Funding cuts have had a greater impact on other areas of the HIV response, though the future remains unclear for harm reduction funding amid Global Fund reprioritisation.

MAURITIUS

Impact on OAT: Impact on NSP:

National government funding supports 80% of the HIV response, increasing resilience to international funding shocks.

MOLDOVA

Impact on OAT: Impact on NSP:

National government funding supports most harm reduction services, increasing resilience to international funding shocks.

UZBEKISTAN

Impact on OAT: Impact on NSP:

Harm reduction is a major component of Global Fund investment in the country, giving it greater protection.

DRUG POLICY AND HUMAN RIGHTS

Over the past year, drug policy reform and harm reduction have continued to be addressed in international fora. Both the United Nations Human Rights Council (HRC) and the Commission on Narcotic Drugs (CND) adopted landmark resolutions, reflecting a growing convergence between drug policy and human rights frameworks. Notably, the HRC adopted a resolution concerning the question of the death penalty (2025), and a resolution addressing the human rights implications of drug policy (2025).

The HRC resolution on the death penalty expresses concern that death sentences continue to be imposed in cases where the threshold of "most serious crimes" has not been met, including drug-related offences. It further requests the Office of the United Nations High Commissioner for Human Rights to organise a high-level panel discussion to address the latest developments, strategies, best practices, and alternative approaches aimed at limiting the use of capital punishment.

The HRC resolution on the human rights implications of drug policy mandates the Office of the High Commissioner for Human Rights to develop a report on the impact of drug policies on the rights of women and girls, and to convene an intersessional panel on the topic before the sixty-fourth session of the Human Rights Council.

In March 2024, the CND reached a historic milestone, for the first time explicitly recognising the role harm reduction in Resolution 67/4. This resolution, focused on preventing and responding to drug overdose through public health measures, emphasised a balanced, evidence-based approach to drug policy. In March 2025, the CND adopted the resolution "Strengthening the international drug control system: a path to effective implementation" (E/CN.7/2025/L.10), which established a multidisciplinary panel of 19 independent experts. The panel is tasked with developing actionable recommendations to enhance the implementation of international drug conventions and related obligations, with the aim of advancing drug policy commitments and contributing to the CND's 2029 review. As such, the panel will be a unique opportunity to critically address the human rights implication of drug control and propose measures to better align contributes to - rather than hindering - the promotion, protection and fulfilment of rights.

In 2024, 34 countries retained the death penalty for drug offences and the use of capital punishment for such crimes increased compared with 2023. At least 615 people were confirmed to be executed for drug offences in 2024, marking the deadliest year on record since 2015. Nearly 40% of all recorded executions globally in 2024 were carried out for drug-related offences. While applications of the death penalty and executions have continued into 2025, there has been one positive development: in June of this year, the government of Vietnam removed the death penalty for certain drug-related offences.

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Methodology

The information presented in the *Global State of Harm Reduction 2025 Update* was gathered with the support of regional and national partners who completed a short survey in September 2025, providing both quantitative and qualitative data. This was complemented by follow-up with respondents and a desk review of relevant literature, including research papers and reports from harm reduction and drug policy colleagues, technical partners, civil society organisations, and networks of people who use drugs.

To report any inaccuracies, please contact us at: office@hri.global or paulina.cortez@hri.global

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