Submission to the OHCHR analytical study on OHCHR analytical study on protection gaps in access to medicines, vaccines and other health products

May 2026

Submitting organisation

Harm Reduction International (HRI) is a leading non-governmental organisation that envisions a world in which drug policies uphold dignity, health and rights. We use data and advocacy to promote harm reduction and drug policy reforms. We show how rights-based, evidence-informed responses to drugs contribute to healthier, safer societies, and why investing in harm reduction makes sense. HRI is an NGO in Special Consultative Status with the Economic and Social Council of United Nation.

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Introduction

Harm Reduction International (HRI) welcomes the opportunity to provide inputs ahead of the OHCHR analytical study on protection gaps in access to medicines, vaccines and other health products, pursuant Human Rights Council's resolution 59/7. This submission answers question b) of the call for inputs, focusing on the impact of cuts in international and domestic funding on the sustainability of harm reduction[1] services globally.

HRI has monitored the international and domestic funding landscape for harm reduction since 2007. This submission draws on HRI's research and experience in the field, and in tracking the impact of the global funding crisis on access to harm reduction for people who use drugs.[2]

For information concerning people deprived of liberty, please refer to the joint submission by Harm Reduction International (HRI), Penal Reform International, the European Prison Litigation Network (EPLN), and Asociatia Romana Anti-SIDA (ARAS), submitted separately to your office under this call for inputs. Information on access to essential medicines and harm reduction services for people who use drug in the community is available in joint submission by HRI, International Drug Policy Consortium (IDPC) and Eurasian Harm Reduction Association (EHRA) to your office in response to the same call.

[1] Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws. It encompasses a range of health and social services and practices that apply to drugs, including but not limited to: Information on safer drug use, drug consumption rooms, needle and syringe program, overdose prevention and reversal, opioid agonist therapy, among other. For more information visit: https://hri.global/what-is-harm-reduction/

[2] For more information visit: https://hri.global/topics/funding-for-harm-reduction/

Unless stated otherwise all information presented in this submission comes from HRI's report The cost of complacency: harm reduction funding crisis.

The impact of the global funding crisis for harm reduction on the access to essential harm reduction medicines and other health care services for people who use drugs.

States must effectively use their maximum available resources to fulfil human rights, including the right to health. Insufficient or misallocation of public expenditure that hinders the enjoyment of rights constitute a breach of this obligation.[3] Access to essential medicines is a core component of the right to health. The World Health Organization (WHO) has recognised methadone and buprenorphine, as well as naloxone, as essential medicines, reflecting their proven effectiveness in reducing overdose, HIV and hepatitis transmission, and other negative consequences that might arise from drug use.

Countries spend over USD 100 billion in drug law enforcement globally every year. In contrast, only USD 151 million was allocated to harm reduction, a proven cost-effective life-saving measures, in low- and middle-income countries (LMICs) in 2022, just 6% of the estimated USD 2.7 billion needed annually, leaving a staggering 94% funding gap. That year, harm reduction programmes accounted for only 0.7% of total HIV funding, even though people who inject drugs accounted for 8% of new HIV infections globally.

Harm reduction has long been reliant on a small number of international donors, being vulnerable to shifting donor priorities and threatening sustainability of lifesaving services. Harm Reduction funding rose slightly between 2022 and 2025, likely reflecting increased prominence in global commitments and international HIV prevention guidelines. However, the suspension of US President's Emergency Plan for AIDS relief (PEPFAR) in 2025, and subsequent cuts to funding, have significantly impacted harm reduction and access to essential medicines for people who use drugs in LMICs.

PEPFAR was the second largest donor in LMICs and the primary donor to the Global Fund. Stop-work orders and subsequent cuts had a negative impact on the availability of services in many countries, such as in Ethiopia, Kenya, Nigeria, Tajikistan, and Tanzania.[4] [5] South Africa, which bears the world's largest HIV epidemic,[6] already had limited access to harm reduction services before 2025 funding cuts. Following the U.S. stop-work order in January 2025,[7] nearly 40 US-supported programmes ended, resulting in the loss of over 8,000 frontline HIV workers and collapsing of prevention and harm reduction services. Access to OAT in prison was closed, disrupting the continuity of care for people in detention, and an estimated 166,354 individuals from key populations lost HIV prevention and

[3] CESCR (2000), General Comment No. 14: The right to the highest attainable standard of health (Art. 12 of the Covenant), UN Doc. E/C.12/2000/4, para. 52.

[4] Harm Reduction International (2026). Key Harm Reduction Messages on Integration for Grant Cycle 8, https://hri.global/wp-content/uploads/2026/02/Key-harm-reduction-messages-on-Integration.pdf, Harm Reduction International (2025), Impact of the US funding cuts on harm reduction. https://hri.global/publications/impact-of-the-us-funding-cuts-on-harm-reduction/

[5] Other examples of the impact of PEPFAR cut on harm reduction services are Kazakhstan, Kyrgyzstan, Mozambique, Nigeria, Uganda and Zambia.

[6] It is estimated that 8.45 million people were living with HIV in South Africa in 2024 at the prevalence rate of 13.9%, and approximately 178,000 new infections annually. The HIV prevalence amongst people who inject drugs is much higher than the national average at 55%. Data required to assess progress towards the 90-90-90 targets for people who inject drugs is not available.

[7] https://www.whitehouse.gov/presidential-actions/2025/01/reevaluating-and-realigning-united-states-foreign-aid/

treatment access. In Tshwane and Ehlanzeni, facilities shut down or scaled back operations, leaving over 5,000 people who use or inject drugs without access to OAT, NSPs, HIV testing, and other essential life-saving services.[8]

A recent modelling study found that one year of disrupted access to harm reduction due to the US funding cuts could result in 9,467 new HIV infections and 13,202 new HCV infections among people who inject drugs in just 9 countries. [9]

In addition to the impact on bilaterally funded programmes, the US funding cuts had major implications for harm reduction supported by the Global Fund.[10] Due to reduced funding, approved Global Fund grant allocations for 2023-2025 were reprioritised, leading to a reduction of harm reduction allocations of $12.83 million across 24 heavily reliant countries.[11] [12] Additionally, reductions in funding for advocacy, human rights and legal and policy reform, crucial enabling activities for harm reduction, were also reduced. As total funds available to the Global Fund have reduced, further reductions in harm reduction support are expected.

Where harm reduction is funded by domestic budgets this protected services from donor turbulence in 2025, and it is needed more than ever to sustain the gains achieved so far. In South Africa, the municipally-funded harm reduction programme became a safety net for thousands of clients who would otherwise have been left without medication or sterile injecting equipment. Similarly, in Indonesia the integration of harm reduction services into primary health care centres and hospitals, funded by the government ensured uninterrupted service delivery. But too few governments are significantly investing, and where they are, this is also fragile in the face of political shifts.[13]

Sudden and dramatic funding and political shifts in global health have driven calls to integrate HIV, tuberculosis (TB) and malaria into national health systems such as primary health cares and universal health coverage.[14] HRI's research cautioned that rushed integrations, without securing sustainable domestic funding, careful planning, and involvement of communities can further weaken the already limited and inadequate HIV prevention and harm reduction services.[15]

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[8] Harm Reduction International. (2025). Impact of US Funding Cuts for Harm Reduction – South Africa Case Study. https://hri.global/wp-content/uploads/2025/10/2611-South-Africa1.pdf

[9] Kipkoech Mutai. K, et al. (2026). Modelling the impact of cuts in US PEPFAR funding for opioid agonist therapy and needle and syringe programmes on drug-related deaths and HIV and hepatitis C transmission among people who inject drugs. International Journal of Drug Policy, 152, 105290. https://www.sciencedirect.com/science/article/pii/S0955395926001428

[10] Harm reduction's dependence on the Global Fund had increased over time, as bilateral support from the UK, Netherlands, Australia and other governments reduced. In 2022, the Global Fund provided 73% of all donor funding for harm reduction, compared to 46% in 2019. More information can be found here: https://hri.global/wp-content/uploads/2026/02/Key-harm-reduction-messages-on-Integration.pdf

[11] Harm Reduction International (2026). Key Harm Reduction Messages on Integration for Grant Cycle 8, https://hri.global/wp-content/uploads/2026/02/Key-harm-reduction-messages-on-Integration.pdf
https://www.dataetc.org/projects/reprioritization/?lang=EN

[12] HRI's unpublished data and analysis estimates that reduction in GC7 reprioritisation process for people who use drugs and their partners is 5.1%.

[13] HRI identified a significant reduction in domestic funding for harm reduction from USD63.2 in 2019 to USD 49.7 million in in 2022. The amount accounted for one-third of total harm reduction funding in low-and-middle-income countries, it is merely 0.4% of all domestic HIV funding.

[14] For example, The Global Fund, in its upcoming grant period from 2026-2028, aims to integrate these disease responses into primary health care and broader health systems to enhance resilience and efficiency, particularly in low and lower middle-income countries and countries with challenging operating environments. More information can be found here: https://hri.global/wp-content/uploads/2026/02/Key-harm-reduction-messages-on-Integration.pdf

[15] Harm Reduction International (2026). Key Harm Reduction Messages on Integration for Grant Cycle 8, https://hri.global/wp-content/uploads/2026/02/Key-harm-reduction-messages-on-Integration.pdf

However, there are positive experiences to draw upon, illustrating that careful planning, inclusive of communities and broader stakeholders, high-level government commitment and viable financing could lead to better integrated services accepted by people who inject drugs.[16]

Recommendations

We encourage the OHCHR to recommend Member States to:

1. Decriminalise drug use and drug possession and promote evidence-based and health and human-rights centred alternatives to incarceration;
2. Divest from punitive drug control, and invest in evidence-based harm reduction programmes -beyond HIV prevention and treatment- ensuring the availability of funding for peer-led and community-led harm reduction initiatives, research, and innovation;
3. Maintain and scale up comprehensive harm reduction services and ensure equitable, voluntary and non-discriminatory access, including in prisons and other closed settings.
4.
5. Publish disaggregated data on harm reduction access, essential medicines, health outcomes and resource allocation to strengthen transparency and accountability

[16] HRI 2026. Harm Reduction integration case study from Bandung, Indonesia (unpublished). Available upon request.