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

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Submitting organisations

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

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The International Drug Policy Consortium (IDPC) is a global network of over 200 civil society and community organisations working together to promote drug policies grounded in social justice and human rights. IDPC is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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Eurasian Harm Reduction Association (EHRA)/Eurazijos žalos mažinimo asociacija is a non-for-profit public membership-based organization uniting 287 harm reduction activists and organisations from Central and Eastern Europe and Central Asia (CEECA) with its mission to actively unite and support communities and civil societies to ensure the rights and freedoms, health, and well-being of people who use psychoactive substances in the CEECA region. EHRA is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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Introduction

Harm Reduction International (HRI), International Drug Policy Consortium (IDPC) and Eurasia Harm Reduction Association (EHRA) welcome 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 a) of the call for inputs, focusing on the main challenges experienced by people who use drugs in accessing essential harm reduction[1] medicines and other health services, including naloxone, Opioid Agonist Therapy (OAT) and Needle and Syringe Programmes (NSPs). It expands on HRI's submissions to the OHCHR pursuant to resolution 53/13 and resolution 56/20.

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 financing for essential harm reduction medicines is available in the submission made by HRI to your office in response to the same call.

Unless stated otherwise all information provided in this submission comes from HRI's Global State of Harm Reduction 2024 and Global State of Harm Reduction: 2025 update to key data.

Main obstacles and challenges experienced by people who use drugs in accessing harm reduction medicines and services.

In 2023 an estimated 316 million people used drugs, of whom 14 million injected drugs in the past year.[2] The risk of acquiring HIV is 34 time higher for people who use drugs than for the general population.[3] They also face increased risk of contracting tuberculosis (TB), and viral hepatitis B and C (HBV and HCV), in addition to overdose and other health complications[4]. The global HIV prevalence among people who inject drugs is 5.0%, compared to 0.7% among the total global adult population.[5] Unsafe drug injection drives an estimated 43.6% of the new HCV

[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 programmes, overdose prevention and reversal, opioid agonist therapy, among others. For more information, please visit https://hri.global/what-is-harm-reduction/

[2] UNODC (2025) World Drug report. Key findings. p 55. https://www.unodc.org/unodc/data-and-analysis/world-drug-report-2025.html

[3] UNAIDS (2026). Fact Sheet 2026. Global Statistics. https://www.unaids.org/en/resources/fact-sheet

[4] Cornford C, Close H. (2016). The physical health of people who inject drugs: complexities, challenges, and continuity. Br J Gen Pract. 66(647):286-7. PMC4871283. https://pmc.ncbi.nlm.nih.gov/articles/PMC4871283/

[5] UNAIDS (2024) Global AIDS targets 2025 for people who use drugs: Where are we now?. https://www.unaids.org/en/resources/documents/2024/global-AIDS-targets-2025-for-people-who-use-drugs-where-are-we-now

infections globally, and the prevalence of current HCV infection among people who inject drugs is 38.8%, approximately 5.8 million people.[6]

Harm reduction is a cost-effective and evidence-based approach endorsed by the whole UN system[7] and recognised as an essential element of the right to health for people who use drugs, including for those deprived of liberty, requiring States to ensure availability, accessibility, acceptability and quality of harm reduction services.[8] The World Health Organization (WHO) has recognised methadone and buprenorphine[9], as well as naloxone[10], as essential medicines, reflecting their proven effectiveness in reducing overdose, HIV and hepatitis transmission, and other negative consequences that might arise from drug use.[11]

However, people who use drug continue to have limited access to those essential medicines and harm reduction services. As of 2025, injecting drug use has been documented in 190 countries, however, only 93 countries provide at least one Needle and Syringe Programme (NSP) and 95 countries provide at least one Opioid Agonist Therapy programme (OAT). At least one drug consumption room (DCR) is present in 19 countries and take-home naloxone programmes are available in 34 countries. Despite some progress in recent years, stimulant prescription or substitution treatment remains limited, with only 6 countries reporting availability, however, most of them are pilot programmes or off-label prescription of already available medications (typically obesity and ADHD medication).[12]

Availability does not guarantee access to timely, quality and voluntarily harm reduction services. Coverage of harm reduction services remain uneven across regions.[13] Only Oceania (Australia and Aotearoa New Zealand) has high NSPs coverage. Central Asia and Western Europe have moderate coverage, while NSP coverage is low in all

[6] Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', The Lancet Global Health, vol. 11, no.5, e659–72. https://doi.org/10.1016/s2214-109x(23)00057-8

[7] United Nations system common position (2018). Supporting the implementation of the international drug control policy through effective inter-agency collaboration https://www.unodc.org/unodc/en/un-common-position-drugs/index.html; International Centre on Human Rights and Drug Policy and UNDP (2020), International Guidelines on Human Rights and Drug Policy. https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy.

[8] CESCR (2000), General Comment No.14 on the right to the highest attainable standard of health. E/C.12/2000/4. https://docs.un.org/en/E/C.12/2000/4; Paul Hunt, (2007) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/4/28/Add.2. https://digitallibrary.un.org/record/594900?ln=en&v=pdf; Anand Grover (2010) Report of the Special Rapporteur on everyone to the enjoyment of the highest attainable standard of physical and mental health. A/65/255, para. 55, https://docs.un.org/en/A/65/255; OHCHR (2023) Report on human rights challenges in addressing and countering all aspects of the world drug problem. A/HRC/54/53 para 11. https://daccessods.un.org/access.nsf/Get?OpenAgent&DS=A/HRC/54/53&Lang=E; Tlaleng Mofokeng (2024); Drug use, harm reduction and the right to health - Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/HRC/56/52 para 21. https://docs.un.org/en/A/HRC/56/52

[9] Drugs commonly used to treat opioid dependence

[10] drug commonly used to prevent and revers opioid overdose

[11] WHO (2025) The selection and use of essential medicines, 2025. WHO Model List of Essential Medicines. 24th list. https://iris.who.int/server/api/core/bitstreams/17642505-ecd3-4940-a691-4f1dfa0d835a/content

[12] The only exception is Czechia, where there is a relatively new, official protocol on stimulant prescription which was approved during the COVID-19 pandemic

[13] Coverage is defined as the number of needles and syringes distributed per person who injects drugs per year: low coverage is under 100 needles; moderate coverage is 100–199 needles; high coverage is 200 needles or above. The World Health Organization-recommended coverage to reach HCV elimination goals are 200 needles per person per year by 2025 and 300 by 2030

other regions. In the case of OAT provision, it is reported to be particularly low in Central Asia, Eastern Europe, Eastern and South Africa and West and Central Africa, where fewer than 2% of people who inject drugs have access to services.

Stigma and criminalisation of people who use drugs hinder access to harm reduction services and undermine the political and financial support needed to implement and expand services. At least 153 countries criminalise drug use and possession[14], and 36 countries retain the death penalty for drug offences.[15] Punitive approaches to drug use have been shown to be ineffective at reducing drug use while worsening health outcomes by limiting the provision of and access to life-saving harm reduction services. Criminalisation is associated with higher HIV and HCV prevalence among people who inject drugs, lower syringe distribution, and increased sharing injecting equipment.[16]

Some people who use drugs face multiple, intersecting vulnerabilities, which further impede access to harm reduction services, including women, LGBTQI+ people, migrants, Indigenous people and people deprived of liberty. Women are significantly less likely to access harm reduction services and other treatments due to the lack of gender-sensitive interventions, heightened stigma and discrimination, restrictive social roles and expectations, and fear of losing custody of their children[17]. Young people also face significant barriers, including age restrictions and services not adapted to their needs. Evidence also shows that drug-related harm rates are disproportionately high for Indigenous People. For instance, opioid overdose deaths are seven times higher for Kainai peoples in Alberta, Canada than for the general population.

Recommendations

We encourage the OHCHR to recommend Member States to:

1. Decriminalise drug use and apply evidence-based and human rights-centred responses to drug use to reduce incarceration rates and promote the right to health;
2. Consider the responsible regulation of internationally controlled substances to ensure better access to essential medicines and reduce harms associated with a toxic drug supply[18];
3. Recognise harm reduction as an essential element of the right to health and ensure availability, accessibility, acceptability and quality of comprehensive harm reduction services, including naloxone, including in prison and other closed settings;

[14] UNAIDS (2024) Global AIDS update. Thematic briefing note. HIV and people who inject drugs. https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update-people-who-inject-drugs_en.pdf
[15] Girelli. G, Jofré. M. and Larasati. A (2026) HRI Global overview 2025. The Death Penalty for Drug Offences: Global Overview 2025. https://hri.global/wp-content/uploads/2026/03/HRI-GO-Death-penalty-drugs-2025-FINAL.pdf
[16] UNAIDS, UNDP and INPUD (2026). Decriminalization of drug use in the context of HIV: a guidance note Creating an enabling legal environment for the HIV response for people who use drugs. P.16. https://www.unaids.org/sites/default/files/2026-03/20260310_Decriminalization-drug-use-HIV.pdf
[17] For more information about the impact of criminalisation on parental and women rights and barriers to harm reduction services in Eurasia visit https://ehra-uploads.s3.eu-central-1.amazonaws.com/8fb8d4bc-17a3-4f5e-bfd0-7614ebcb91eb.pdf
[18] As already recommended by OHCHR, UNDP and the UN Special Rapporteur on the right to health

4. Ensure that harm reduction services are tailored to the diverse needs of people who use drugs, including youth, women, LGBTQI+ people, migrants, ethnic minorities and Indigenous Peoples.
5. Remove legal, policy and administrative barriers that prevent access to harm reduction services and essential medicines for people who use drugs, including youth, women, migrants, ethnic minorities and Indigenous population;
6. End coercive, compulsory and discriminatory drug treatment practices and ensure all services are voluntary, evidence-based and grounded in informed consent
7. Collect and publish disaggregated data on access to, and availability of, harm reduction services, essential medicines, overdose, HIV and hepatitis outcomes and public expenditure related to drug policy and health responses
8. Ensure the meaningful participation of people who use drugs and other affected communities in the design, implementation and evaluation of laws, policies and programmes affecting them.