**Submission to the Office of the High Commissioner of Human Rights (OHCHR) to the analytical report on the impact, results and state of implementation of societal enablers by States, as recognized in the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030**

October 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.

## Introduction

Harm Reduction International (HRI) welcomes the opportunity to contribute to the OHCHR's analytical report on report on the impact, results and state of implementation of societal enablers by States, as recognized in the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, pursuant to Human Right Council resolution 56/20.

This submission will focus on questions 1, 2, 4 and 7.

For further information on this issue, please see HRI's previous submissions to your Office. These include 2026 submissions to the OHCHR analytical study on protection gaps in access to medicines, vaccines and other health products: joint submission on access to medicines and harm reduction, HRI's submission on access to medicines and sustainable financing for harm reduction and joint submission on the same issue focusing on people deprived of liberty. Relevant reference to harm reduction and HIV related to this analytical report can also be found in 2025 submissions to the OHCHR's report on sustainable HIV responses with regard to the human rights of persons living with, at risk of or affected by HIV, including HRI's submission on harm reduction and HIV responses and joint submission on HIV responses and human rights on prisons.

Question 1

*What frameworks, measures and policies are in place to strengthen rights-based country leadership and ownership and ensure integrated, people-centred multi-sectoral national HIV responses to ensure services and impact beyond 2030, with sustained domestic and international funding, as appropriate from bilateral and multilateral donors[3.1]? What frameworks, measures and policies are in place to ensure sustaining gains and building durable HIV responses[3.2]?*

Harm reduction is internationally recognised as an essential component of an effective, evidence-based HIV response. The 2021 UN Political Declaration on HIV and AIDS explicitly recognises harm reduction as part of combination HIV prevention and commits states to expanding access to these interventions.[1] Methadone and buprenorphine are also included in WHO's Model List of Essential Medicines for opioid use disorders.[2]

This recognition is increasingly reflected in national policies. As of 2025, 112 countries explicitly recognise harm reduction in national policy documents.[3] However, policy recognition does not necessarily translate into adequate service provision or sustainable domestic financing. In low- and middle-income countries (LMICs), just USD 151 million was invested in harm reduction in 2022, against an estimated annual requirement of USD 2.7 billion. Recent international funding cuts have further exposed the fragility of services, including through closures and reduced community-led capacity.[4]

Governments must translate commitments into predictable domestic financing and integrate HIV and harm reduction services into primary healthcare, in prisons and post-release care, in accordance with human rights obligations. International assistance remains essential where domestic resources are insufficient. National strategies must also address criminalisation and discriminatory practices, ensure meaningful community participation in resource allocation and service delivery, and incorporate community-led monitoring of discrimination, accessibility and continuity of care.

---

[1] UN General Assembly, Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 (2021), https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf.

[2] WHO, The Selection and Use of Essential Medicines, 2025: WHO Model List of Essential Medicines, 24th list, section on medicines for opioid use disorders, https://www.who.int/publications/i/item/B09474.

[3] Harm Reduction International (2025), Global State of Harm Reduction: 2025 Update to Key Data (GSHR 2025 Update to Key Data), https://hri.global/publications/global-state-of-harm-reduction-2025-update-to-key-data/. This also documents the disparity between policy recognition and service availability, including limited provision in prisons and the impact of international funding cuts.

[4] Harm Reduction International (2024), The Cost of Complacency: A Harm Reduction Funding Crisis, https://hri.global/flagship-research/funding-for-harm-reduction/cost-of-complacency/. The USD 151 million figure refers to identified harm reduction funding in low- and middle-income countries in 2022, compared with the estimated USD 2.7 billion annual requirement by 2025.

Question 2

*What programs, measures or policies are in place to ensure that less than 10 percent of people living with, at risk of, or affected by HIV experience stigma and discrimination? Have these had a measurable impact on the reduction of stigma and discrimination?*

Effective measures must address both interpersonal stigma and the laws and institutional practices that sustain it. Priorities include anti-discrimination protections, accessible complaints and legal redress mechanisms, training for healthcare professionals and law enforcement, and voluntary, confidential services led by or developed with affected communities. Decriminalising drug use and possession for personal use, removing barriers to harm reduction and ending arbitrary detention can help reduce fear of seeking HIV testing, treatment and prevention.

Community-led harm reduction programmes provide practical models for reaching people who may avoid mainstream services, because peers help to design, deliver and evaluate them. HRI's joint submission to OHCHR on access to medicines and harm reduction documents persistent legal, policy and institutional barriers to accessing essential harm reduction medicines and services, and calls for their removal.[5] HRI's GSHR 2024 also documents persistent gaps in service availability, including in prisons, and highlights how punitive drug policies fuel stigma and deter people from seeking care.[6] Harm reduction received only 0.7% of HIV funding in 2022, although people who inject drugs accounted for 8% of new infections. HRI's research further demonstrates that funding cuts have resulted in service closures and interruptions to outreach activities.[7]

However, programme availability alone does not demonstrate reduced stigma. Governments should measure progress through disaggregated surveys, including the People Living with HIV Stigma Index, community-led monitoring and reporting of discrimination in healthcare, detention and community settings. UNAIDS data show that stigma remains widespread; the global target of fewer than 10% experiencing stigma and discrimination has not been achieved.[8]

[5] Harm Reduction International, International Drug Policy Consortium and Eurasian Harm Reduction Association, *Joint Submission to OHCHR – Access to Medicines and Harm Reduction*, https://hri.global/publications/joint-submission-to-ohchr-access-to-medicines-and-harm-reduction/.
[6] Harm Reduction International, Global State of Harm Reduction 2024 (GSHR 2024), https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2024/.
[7] GSHR 2025 Update to Key Data, p.11.
[8] UNAIDS, Global AIDS Update 2025, https://www.unaids.org/sites/default/files/2025-07/2025-global-aids-update-JC3153_en.pdf.

Question 4

*What frameworks, laws, legal reforms, policies and strategies are in place, to ensure reduction in restrictive legal and policy frameworks that unfairly target people living with, at risk of and affected by HIV, including age of consent laws and laws related to HIV non-disclosure, exposure and transmission and those that impose HIV-related travel restrictions and mandatory testing, and lead to the denial or limitation of access to services?*

Criminalisation of drug use and possession, restrictions on harm reduction, compulsory rehabilitation and punitive policing obstruct HIV prevention, treatment and care. Detention may further disrupt treatment continuity where equivalent harm reduction and HIV services are unavailable. HRI's research on human rights in detention identifies inadequate access to essential harm reduction interventions as a persistent concern.[9] Age restrictions also create barriers as, in some countries, people under 18 are formally excluded from needle and syringe programmes and drug consumption rooms, limiting adolescents' access to essential harm reduction services.[10] Restrictive HIV-specific laws and practices—including criminalisation of non-disclosure, exposure or transmission, mandatory testing and travel restrictions—also require review to ensure they are evidence-based, proportionate and consistent with human rights obligations.[11]

Good practice includes decriminalising drug use and possession for personal use, removing legal obstacles to evidence-based harm reduction, replacing compulsory treatment with voluntary healthcare, and guaranteeing equivalent services in detention and after release. Governments should also remove age-related barriers and ensure that adolescents can independently consent to HIV testing, treatment and harm reduction services, in accordance with their evolving capacities and best interests.[12][13] Reform must be assessed through implementation, not legislation alone: governments should monitor enforcement practices, police harassment, access to confidential services, treatment retention and community-reported experiences. UNAIDS has emphasised that punitive legal environments undermine access to HIV services and progress towards ending AIDS.[14]

[9] GSHR 2024, pp. 75 – 88.
[10] GSHR 2024, p. 30.
[11] UNAIDS, Global AIDS Briefing, June 2026, https://www.unaids.org/sites/default/files/2026-06/20260612_global_aids_brief_1.pdf, pp. 19-20.
[12] Damon Barrett, Frida Peterssen, Russell Turner, Access to Services for Under 18s Who Inject Drugs: Age Barriers, Fear of Discovery, Harm reduction Strategies and the Transition to Adulthood , YOUNG 0(0), https://journals.sagepub.com/doi/10.1177/11033088251409399.
[13] UNAIDS, Decriminalization of drug use in the context of HIV: a guidance note, https://www.unaids.org/en/resources/documents/2026/20260310_Decriminalization-drug-use-HIV.
[14] Ibid.

Question 7

*What programs, measures or policies are in place to ensure that community leadership meets the 30-80-60 targets[3.3]? Have these had a measurable impact? What public financing mechanisms are in place to fund community-led organisations, and what share of national HIV funding do they receive?*

Achieving the 30-80-60 targets requires more than consultation: communities must have decision-making authority, adequate resources and the capacity to independently monitor implementation. In many LMICs, there are few public policies or measures to ensure community leadership in achieving these targets, while community-led service delivery remains heavily dependent on international donors. HRI's 2024 research found little evidence that progress towards the 30-80-60 targets was being adequately monitored.[15] Similarly, fewer than half of Global Prevention Coalition countries had set targets for community-led services, falling to just 4 of 14 countries where HIV epidemics primarily affect key populations.[16] In 2020, less than 10% of Global Fund prevention funding for people who inject drugs went to community-based organisations.

Funding data reaching community-led organisations remain insufficiently transparent in many settings, making impact difficult to assess. Although social contracting offers a mechanism for channelling public resources to community-led organisations, its availability remains limited and funding is often small-scale, restrictive and unpredictable.[17] Governments should establish direct, accessible and predictable multi-year public funding for community-led organisations, including those led by people who use drugs, through dedicated budget lines and simplified grant procedures. They should also publish disaggregated budget and expenditure data, identify barriers to accessing public resources, and track funding by recipient leadership and service area. UNAIDS' 2026 technical guidelines provide a framework for costing and budgeting sustainable community-led HIV responses.[18]

[15] HRI, The Cost of Complacency: A Harm Reduction Funding Crisis, p. 38
[16] Ibid,
[17] Harm Reduction International (2023), *Towards Domestic Public Financing and Social Contracting for Harm Reduction*, https://hri.global/wp-content/uploads/2023/04/SOCIAL-CONTRACTING_FINAL.pdf. See also HRI (2025), *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/; HRI (2026), *Investing in Advocacy to Increase Harm Reduction Funding: Evidence of What Works*, https://hri.global/wp-content/uploads/2026/03/Budget-advocacy.pdf.
[18] UNAIDS (2026), *Sustaining HIV Community-led Responses: Technical guidelines for costing and budgeting,* https://www.unaids.org/en/resources/documents/2026/20260506_UNAIDS-Community-led-HIV-response.