Submission to the Multidisciplinary Expert Panel on Strengthening the International Drug System pursuant resolution 68/6

November 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 the United Nations.

Contact details: Marcela Jofré, Human Rights Analyst, marcela.jofre@hri.global

Introduction

Harm Reduction International (HRI) welcomes the opportunity to contribute to the Expert Panel's work on building clear, specific and actionable recommendations aimed at enhancing the implementation of the three drug control conventions, other international instruments and all international drug policy commitments, to inform the review of the international drug policy commitments in 2029.

Drawing on HRI's expertise and publications, this submission focuses on the recognition of harm reduction as integral to international drug policy commitments and the broader international framework, and on the barriers that the drug control framework places on its full implementation.

Harm reduction is a life-saving and cost-effective approach to drug use.[1] It 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.[2] It encompasses a range of health and social services and practices that can be adapted to country specific contexts, including but not limited to information on safer drug use, drug consumption rooms (DCRs),

[1] See for example; Behrends, C. N., Leff, J. A., Lowry, W., Li, J. M., Onuoha, E. N., Fardone, E., Bayoumi, A. M., McCollister, K. E., Murphy, S. M., & Schackman, B. R. (2024). Economic evaluations of establishing opioid overdose prevention centers in 12 North American cities: A systematic review. Value in Health, 27(5), 655–669. https://doi.org/10.1016/j.jval.2024.02.004; Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. International Journal of Drug Policy, 26(Suppl. 1), S5–S11. https://doi.org/10.1016/j.drugpo.2014.11.00

[2] Harm Reduction International. (2026). What is harm reduction? https://hri.global/what-is-harm-reduction/

Needle and Syringe Programmes (NSPs), overdose prevention and reversal, Opioid Agonist Therapy (OAT), and drug checking.[3]

I. International drug policy commitments and the recognition of harm reduction.

The drug conventions are underpinned by "health and welfare of mankind."[4] As early as 2002, the UN International Drug Control Programme[5] concluded that the 1998 Declaration on the Guiding Principles of Drug Demand Reduction[6] could be read as "a clear mandate" for harm reduction policies, including "needle and syringe exchange", "substitution and maintenance treatment" and "drug-injection rooms".[7] The International Narcotics Board (INCB) stated that OAT does not breach treaty provisions and that governments should adopt measures that may decrease the sharing of needles, such as NSPs.[8] It has since recognised that methadone and buprenorphine[9] "should be considered first-line treatment options" for opioid dependence, and that naloxone should be available for overdose treatment,[10] in line with their inclusion in the WHO Model List of Essential Medicines.[11]

Harm reduction has been recommended by the whole UN system,[12] and endorsed by the General Assembly[13], the CND[14] and the Human Rights Council.[15] It is key to achieving the Sustainable Development Goals[16] and

[3] World Health Organization. (2023). Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs: Policy brief. https://www.who.int/publications/i/item/9789240071858; European Union Drugs Agency. (2026). Harm reduction – the current situation in Europe (European Drug Report 2026). https://www.euda.europa.eu/publications/european-drug-report/2026/harm-reduction_en; Mofokeng, T. (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). United Nations Human Rights Council. https://www.ohchr.org/en/documents/thematic-reports/ahrc5652-drug-use-harm-reduction-and-right-health-report-special

[4] Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol, preamble, para. 1; Convention on Psychotropic Substances, 1971, preamble, para. 1

[5] Programme UNODC's predecessor

[6] Adopted through General Assembly resolution S-20/3

[7] International Drug Policy Consortium (2008). Flexibility of treaty provisions as regards harm reduction approaches. https://idpc.net/publications/2008/02/flexibility-of-treaty-provisions-as-regards-harm-reduction-approaches; Decision 74/10. Flexibility of treaty provisions as regards harm reduction approaches (E/INCB/2002/W.13/SS.5). https://bookofauthorities.info/documents/2002/decision-7410-flexibility-of-treaty-provisions-as-regards-harm-reduction-approaches-eincb2002w-13ss-5/

[8] INCB. (2003) INCB Annual Report 2003. E/INCB/2003/1. para 221 file:///C:/Users/Marcela%20Jofre/Downloads/AR_03_English%20(1).pdf

[9] Medicines traditionally use for Opioid substation treatment

[10] INCB (2018) Report of the International Narcotics Control Board for 2017. E/INCB/2017/1. p. 9, 11, 12 among others. https://www.incb.org/incb/uploads/documents/Publications/AnnualReports/AR2017/Annual_Report/E_2017_AR_ebook.pdf

[11] WHO (2026) Model list of essential medicines. https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists

[12] UN Common position. Supporting the implementation of the international drug control policy through effective inter-agency collaboration https://www.unodc.org/res/un-common-position-drugs/index_html/2315371E-eBook.pdf

[13] A/RES/S-30/1 (2016); A/RES/70/266 (2016), para 43. A/RES/S-26/2 (2001), para 52. A/RES/75/284 (2021), paras 36, 37 and 60(a); A/80/L.79 (2026) para 23, 56

[14] CND resolution 67/4

[15] A/HRC/RES/12/27 (2009); A/HRC/RES/16/28 (2011); A/HRC/RES/47/14 (2021); A/HRC/RES/52/24 (2023); A/HRC/RES/56/20 (2024) A/HRC/RES/60/26 (2025)

[16] Particularly targets 1.4, 3.3; 3.5, 3.8, 5.2, and 10, among others. For more information, see: Health Poverty Action (2015) Drug Policy and the Sustainable Development Goals. Why drug policy reform is essential to achieving the Sustainable

essential to the HIV response.[17] The WHO, UNODC and UNAIDS Technical Guide - which states endorsed in the 2016 UNGASS Outcome Document[18] - sets out a comprehensive package of evidence-based interventions for people who inject drugs, including NSPs and OATs.[19] The WHO's consolidated guidelines for key populations[20] reaffirm these interventions as essential health services.[21]

Harm reduction is grounded in States' obligations to respect, protect and fulfil the rights to life and to the highest attainable standard of physical and mental health. Under article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) the right to health requires health facilities, goods and services to be available, accessible, acceptable of good quality, and without discrimination.[22] The Committee on Economic, Social and Cultural Rights (CESCR) has identified access to essential medicines, including those on the WHO's Model List, as core obligation.[23] The right to life, as interpreted by the Human Rights Committee, requires States to "take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individual from enjoying their right to life with dignity" including drug-related harms and HIV prevalence.[24] These obligations require States to take evidence-based measures to prevent avoidable harm and ensure access to essential health interventions.

UN human rights treaty bodies and mechanisms have repeatedly urged States to make harm reduction services available, accessible, on a voluntary basis, including gender-specific services and have called to address barriers arising from stigma, discrimination and criminalisation.[25] These obligations extend to people deprived of liberty, in

---

Development Goals.
https://www.unodc.org/documents/ungass2016/Contributions/Civil/Health_Poverty_Action/HPA_SDGs_drugs_policy_briefing_WEB.pdf

[17] UNAIDS (2026). The global AIDS strategy for 2026–2031: United towards ending AIDS (UNAIDS/JC3167E). https://www.unaids.org/sites/default/files/2026-04/2026%E2%80%932031_Global-AIDS-Strategy.pdf; UNAIDS (2025) 2 Draft recommendations - Global Task Team for Setting 2030 HIV Targets https://www.unaids.org/sites/default/files/2025-05/20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf

[18] UNGASS (2016) Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem New York, 19-21 April 2016 Our joint commitment to effectively addressing and countering the world drug problem. p 7. https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf

[19] WHO, UNODC, UNAIDS (2012). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. p 10-13. https://iris.who.int/server/api/core/bitstreams/19d2296b-0bd4-4412-9156-5033e427497e/content

[20] Men who have sex with men, trans and gender diverse people, sex workers, people who inject drugs and people in prisons and other closed settings

[21] WHO (2022). Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization p. 59. https://www.who.int/publications/i/item/9789240052390

[22] The right to health is also provided for in several other international human rights instruments, including the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5 (e) (iv)) and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (arts. 28 and 43)

[23] CESCR (2000). CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). E/CN.4/2000/4. para. 43(d)). https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf

[24] Human Rights Committee (2019). General Comment 36 (2018), CCPR/C/GC/36. para. 26. https://docs.un.org/en/ccpr/c/gc/36

[25] See for example: A/65/255. para 50-55. https://docs.un.org/en/A/65/255; CRC/C/PRT/CO/5-6 para 36. https://docs.un.org/en/CRC/C/PRT/CO/5-6; E/C.12/MUS/CO/5. para 54. https://docs.un.org/en/E/C.12/MUS/CO/5; E/C.12/ECU/CO/4 para 48. https://docs.un.org/en/E/C.12/ECU/CO/4; A/77/197. Para 79-100 https://docs.un.org/en/A/77/197; CCPR/C/CAN/CO/7.para 33-34 https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/download.aspx?symbolno=ccpr%2fc%2fcan%2fco%2f7&lang=en; A/HRC/56/52. https://docs.un.org/en/A/HRC/56/52; A/HRC/63/56 para 37-43

accordance with the principle of equivalence of care[26].[27] Denial of access to harm reduction may constitute torture and other cruel, inhuman and degrading treatment.[28]

II. Limitations of the current international framework as barrier to expanding and accessing the full range of harm reduction services for all people who use drugs.

Harm reduction is grounded in scientific evidence and international drug control and human rights obligations. These commitments must be integrated and interpreted systematically under the overarching principle of full respect for human rights, one of the purposes of the United Nations.

In practice, however, the international drug control framework hinders the full provision of harm reduction. The drug conventions prioritise punitive approaches to drug use and require States to limit drug use exclusively to medical and scientific purposes.[29] Decades of law enforcement, seizures, and prohibition have not eliminated drug markets, reduced drug use, nor prevented the emergence of new psychoactive substances. Drug use continues to rise: 331 million people having used drugs in 2024, 34% more than a decade ago.[30]

Despite decriminalisation of drug use and possession for personal use being endorsed by international fora,[31]at least 153 countries criminalise them.[32] Punitive approaches 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 and other essential health services. Criminalisation is associated with higher HIV and HCV prevalence among people who inject drugs, lower syringe distribution, and increased sharing injecting equipment.[33]

---

https://www.ohchr.org/sites/default/files/documents/hrbodies/hrcouncil/sessions-regular/session63/a-hrc-63-56-auv.pdf; A/HRC/63/72 para 64-65 https://docs.un.org/en/A/HRC/63/72

[26] According to Mandela Rules (24 (1) and Principle 9 of UN Basic Principles for treatment of prisoners; people in prison should enjoy the same standards of health care that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

[27] See for example: A/65/255 (2010), paras. 50–55. https://docs.un.org/en/; A/65/255; CRC/C/PRT/CO/5-6 (2019), para. 36. https://docs.un.org/en/; CRC/C/PRT/CO/5-6; E/C.12/MUS/CO/5 (2019), para. 54. https://docs.un.org/en/; E/C.12/MUS/CO/5 (2019) para 53-54 https://docs.un.org/en/E/C.12/MUS/CO/5; E/C.12/ECU/CO/4 (2019), para. 48. https://docs.un.org/en/; E/C.12/ECU/CO/4 para 47-48 https://docs.un.org/en/E/C.12/ECU/CO/4; A/77/197 (2022), paras. 79–100. https://docs.un.org/en/A/77/197; CCPR/C/CAN/CO/7 (2026), paras. 33–34. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/download.aspx?symbolno=ccpr%2fc%2fcan%2fco%2f7&lang=en; A/HRC/56/52 (2024) https://docs.un.org/en/A/HRC/56/52; A/HRC/63/56 (2026), paras. 37–43. https://www.ohchr.org/sites/default/files/documents/hrbodies/hrcouncil/sessions-regular/session63/a-hrc-63-56-auv.pdf; A/HRC/63/72 (2026), paras. 64–65. https://docs.un.org/en/A/HRC/63/72

[28] A/HRC/10/44 (2009) para.71-74 https://docs.un.org/en/A/HRC/10/44

[29] INCB (2023) International Narcotics Control Board. Report 2022. E/INCB/2022/1. paras 62, 64 and 66–69 https://www.incb.org/incb/uploads/documents/Publications/AnnualReports/AR2022/Annual_Report/E_INCB_2022_1_eng.pdf

[30] UNODC (2026) World Drug Report 2026. Highlights. p.1 https://www.unodc.org/documents/data-and-analysis/WDR_2026/WDR26_Highlights.pdf

[31] Cite HRC, UNGAS, HIV, common position etc

[32] 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

[33] 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 https://www.unaids.org/sites/default/files/2026-03/20260310_Decriminalization-drug-use-HIV.pdf; A/HRC/56/52 (2024), para 31-36 https://docs.un.org/en/A/HRC/56/52

Opioid overdoses can be reversed with naloxone. WHO recommends making naloxone available to people likely to witness an overdose, including people who use drugs, their families and friends.[34] In many countries, naloxone is available only on prescription or to medical staff, keeping it from those best placed to use it in the first minutes of an overdose. Fear of arrest, stigma and restrictive dispensing rules prevent people from seeking emergency assistance or accessing naloxone.[35] Life-saving interventions remain inaccessible when it is most urgently needed.

These barriers are particularly acute in detention, where harm reduction remains far less available than in the community. As of 2025, 61 countries have implemented OAT in at least one prison, 11 have NSPs in at least one prison. Naloxone on release is available in at least one prison in 11 countries mostly in Europe, North America, and one scheme in Oceania (Australia). Only one country (Canada) has implemented at least one drug consumption room in prison.[36]

Drug-related offences account for 22% of the global prison population[37] and 19% of people incarcerated for drug offences are held for possession for personal use.[38] The burden of incarceration falls disproportionately on marginalised groups, particularly women. Globally, one in three women are incarcerated for drug offences, rising to 60-80% in some Latin American and Asian countries. A large share of them is in pre-trial detention.[39]

The prevailing punitive approach means that resources are overwhelmingly channelled into supply and demand reduction, at the expense of harm reduction and health.[40] An estimated USD 100 billion is spent each year on global drug law enforcement, over 750 times the amount allocated to harm reduction services for people who use drugs.[41] Development aid, has also funded punitive drug control.[42] Between 2012 and 2021, at least USD 974 million of aid was spent on "narcotics control" projects.[43] These funds supported law enforcement equipment and

[34] WHO (2014) Substance use. Community management of opioid overdose https://iris.who.int/server/api/core/bitstreams/66b902c1-77e3-4971-adaf-71551b3995b9/content

[35] A/HRC/56/52 (2024) para 65 https://docs.un.org/en/A/HRC/56/52

[36] Harm Reduction International (2024). The Global State of Harm Reduction 2024. https://hri.global/wp-content/uploads/2024/10/GSR24_full-document_12.12.24_B.pdf; Harm Reduction International (2025) Global State of Harm Reduction: 2025 update to key data. https://hri.global/publications/global-state-of-harm-reduction-2025-update-to-key-data/

[37] Penal Reform International. (2026) Global Prison Trend 2026. https://www.penalreform.org/resource/global-prison-trends-2026/

[38] Penal Reform International. (2026) Global Prison Trend 2026. https://www.penalreform.org/resource/global-prison-trends-2026/

[39] In countries such as Bolivia, Panama, Paraguay and Uruguay, the number of women in pre-trial detention exceeds those serving sentences, with drug policies identified as a key contributing factor. For more information visit: 39Jeffries. S and Owen. B. (2025). Locked Away While Innocent: Women, Human Rights, and Pre-Trial Detention. Laws, 14(5), 75. https://www.mdpi.com/2075-471X/14/5/75

[40] See for example the case of Philippines here: https://hri.global/wp-content/uploads/2026/08/Final_Briefing-PHL-punitive-funding.pdf

[41] Harm Reduction International (2021) Divest. Redirect. Invest. The case for redirecting funds from ineffective drug law enforcement to harm reduction- Spotlight on six months in Asia. https://hri.global/publications/divest-redirect-invest-the-case-for-redirecting-funds-from-ineffective-drug-law-enforcement-to-harm-reduction-spotlight-on-six-countries-in-asia/; Harm Reduction International (2016) The case for harm reduction decade: progress, potential and paradigm shifts. https://hri.global/publications/the-case-for-a-harm-reduction-decade/

[42] 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/

[43] Harm Reduction International (2023). Aid for the war on drugs. https://hri.global/wp-content/uploads/2023/09/HRI_Aid-for-the-War-on-Drugs_Final-1.pdf

training, undercover policing and "intelligence-led profiling", and at least USD 70 million went to projects in 16 countries that retain the death penalty for drug offences.[44]

In contrast, harm reduction funding in low- and middle-income countries (LMICs), met just 6% of the estimated USD 2.7 billion needed annually in 2022. Much of that funding came from international donors, with just USD 49.7 million, or 1.7% of the estimated need, coming from domestic funding sources. Even where governments are funding the HIV response, funding for harm reduction accounted for 0.4% of all domestic funding for HIV in 2022.

The funding crisis has deepened even further, as funding from international donors has reduced significantly with the suspension of US President's Emergency Plan for AIDS relief (PEPFAR) in 2025, and several donor countries reducing their contributions to the Global Fund.[45] This inadequate allocation of resources is not compatible with States' obligation under ICESCR to devote the maximum available resources to realising the right to health, including through international assistance. Public funds are directed to measures that harm health and rights while life-saving services remain chronically underfunded.[46]

Taken together, these barriers show that harm reduction cannot be fully implemented while the punitive approach entrenched in the international drug control framework prevails.

III. **Good practices in harm reduction and their adaptation to national context.**

As of 2025, 93 countries provide at least one NSP and 95 provide at least one OAT. DCRs are available in 19 countries and take-home naloxone programmes in 34. Only six countries report stimulant prescription or substitution treatment, mostly through pilot programmes or off-label prescription of existing medicines.[47]

Harm reduction must respond to different drug use patterns and domestic contexts, with services tailored to people's needs and shaped by peer leadership. DCRs[48] vary in design and operation, including stand-alone, integrated, and mobile models.[49] Across models, evidence shows that DCRs can reduce overdose-related morbidity and mortality, reduce risk of contracting infectious diseases, and facilitate access to treatment and other health and social services.[50] In **Australia**, the stand-alone United Medically Supervised Injecting Centre, has

---

[44] Harm Reduction International (2023). Aid for the war on drugs. pp 2, 11, 13–14 and 17. https://hri.global/wp-content/uploads/2023/09/HRI_Aid-for-the-War-on-Drugs_Final-1.pdf .

[45] See for example the impact of Funding cuts in Kenya (https://hri.global/publications/the-impact-of-us-funding-cuts-and-reduced-financing-on-harm-reduction-in-kenya/); South Africa (https://hri.global/publications/breaking-point-the-impact-of-us-funding-cuts-on-harm-reduction-in-south-africa/); Indonesia (https://hri.global/publications/the-impact-of-us-funding-cuts-on-harm-reduction-in-indonesia/), and Kazakhstan (https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-kazakhstan/)

[46] 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.

[47] Harm Reduction International (2024). The Global State of Harm Reduction 2024. https://hri.global/wp-content/uploads/2024/10/GSR24_full-document_12.12.24_B.pdf; Harm Reduction International (2025) Global State of Harm Reduction: 2025 update to key data. https://hri.global/publications/global-state-of-harm-reduction-2025-update-to-key-data/

[48] Also known as supervised consumption sites, safe injection sites, and overdose prevention centres

[49] Kerr. T, Kennedy, M.C, & Daniels, C., (2025) Drug Consumption Rooms Service models and evidence. https://hri.global/wp-content/uploads/2025/03/DCRs_ServiceModels_Evidence.pdf

[50] Kerr. T, Kennedy, M.C, & Daniels, C., (2025) Drug Consumption Rooms Service models and evidence. https://hri.global/wp-content/uploads/2025/03/DCRs_ServiceModels_Evidence.pdf

supervised around 1.28 million injections since its opening in 2001 and managed 11,205 overdoses without a fatality.[51] In **the US**, OnPoint NYC operates two DCRs each within an integrated "Harm Reduction Hub", offering services, including NSPs, drug checking, clinical and mental health care, and peer support. In its first year, the sites recorded 48,533 drug consumption episodes involving 2,841 individuals.[52] In **Colombia,** Cambie, an unsanctioned DCR, received 1564 visits in its first year and offers psychological support, food and referral to external services.[53]

Harm reduction can also reflect Indigenous knowledge and community priorities.[54] In **Canada**, Alberta Health Service has supported a Kainai response to the "fentanyl crisis" underpinned by *'kímmapiiyipitssini',* a Blackfoot concept emphasising compassion and not giving up on people*.* [55]continuum-of-care approach connects prevention, harm reduction, treatment, supportive housing and community care, including naloxone distribution and education.

Harm reduction can adapt to reach diverse and often marginalised populations. In **Vietnam**, community health workers are enabling OAT provision in rural areas far from clinics. In **Thailand**, a facility tailored to LGBTQ+ people who inject drugs opened in 2022, integrating health and harm reduction services.[56] In **Ukraine**, the first prison NSP opened in 2023 in collaboration with a peer-led NGO Free Zone. By July 2024, 592 people had received around 19,500 services from the NSP, and 13 people in prison had become peer workers to support social reintegration after release.[57]

Effective models cannot expand without sustainable financing. Harm reduction has historically relied on a few international donors, leaving services vulnerable to changing priorities. The 2025 suspension of US President's Emergency Plan for AIDS Relief (PEPFAR) activities and subsequent funding cuts disrupted harm reduction and access to essential medicines in LMICs. [58]

Domestic financing can help protect services from external funding shocks. In **South Africa**, the harm reduction programme, funded by the City of Tshwane, provided a safety net for thousands of clients who would otherwise

[51] Kerr. T, Kennedy, M.C, & Daniels, C., (2025) Drug Consumption Rooms Service models and evidence. https://hri.global/wp-content/uploads/2025/03/DCRs_ServiceModels_Evidence.pdf

[52] Kerr. T, Kennedy, M.C, & Daniels, C., (2025) Drug Consumption Rooms Service models and evidence. https://hri.global/wp-content/uploads/2025/03/DCRs_ServiceModels_Evidence.pdf

[53] Kerr. T, Kennedy, M.C, & Daniels, C., (2025) Drug Consumption Rooms Service models and evidence. https://hri.global/wp-content/uploads/2025/03/DCRs_ServiceModels_Evidence.pdf

[54] For more information visit: Harm reduction International (2024) Global State of Harm Reduction 2024. p 62-72 https://hri.global/wp-content/uploads/2024/10/GSR24_full-document_12.12.24_B.pdf

[55] a Blackfoot term meaning 'to give kindness to each other

[56] Harm reduction International (2024) Global State of Harm Reduction 2024. p 117 https://hri.global/wp-content/uploads/2024/10/GSR24_full-document_12.12.24_B.pdf

[57] Harm reduction International (2024) Global State of Harm Reduction 2024. p 77 https://hri.global/wp-content/uploads/2024/10/GSR24_full-document_12.12.24_B.pdf

[58] For more details on the impact of funding crisis visit: https://hri.global/publications/impact-of-the-us-funding-cuts-on-harm-reduction/

have been left without medication or sterile injecting equipment.[59] Similarly, in **Indonesia** the integration of harm reduction services into primary health care, funded by the government, ensured uninterrupted service delivery.[60]

IV. Conclusion and recommendations:

Consistently with what is required by Resolution 68/6, the Expert Panel must ensure a holistic approach to its deliberations; which considers all relevant international obligations, including those related to human rights, health, and sustainable development. Considering panel's mandate and the evidence presented in this submission, we encourage the panel to:

- Recognise that the overarching aim of the system- promoting health and welfare of humankind- should be read through the prism of available science, to set up realistic and achievable goals for drug policies that prioritise health and rights; and accordingly, promote adoption of indicators to evaluate drug policies that integrate health and human rights outcomes, including access to harm reduction and essential medicines, and reduction in HIV infections and overdose deaths;
- Recognise that the prohibitionist orientation of the current drug control regime hinders the full implementation and scale-up of harm reduction and health-centred policies; accordingly, identify pathways for reform of the international drug control architecture necessary to move away from punitive approaches and the unrealistic goal of a "drug-free world", towards evidence-based approaches grounded in public health and human rights, with all relevant UN entities, including WHO and OHCHR, engaged as equal partners.
- Reaffirm harm reduction as a minimum core obligation of States under the right to health and international drug policy commitments, and recommend that harm reduction services be available, accessible, acceptable and of good quality for all people who use drugs, provided on a voluntary basis, and adequately and sustainably funded.
- Recommend the decriminalisation of drug use and possession for personal use, and of harm reduction equipment and overdose response, as consistent with the conventions and necessary for access to services;
- Call on States to fund harm reduction sustainably to the maximum of available resources, protect harm reduction budgets from retrogressive cuts, and redirect resources from enforcement into health.

[59] Harm Reduction International (2025). Impact of PEPFAR funding cuts in harm reduction in South Africa. https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-south-africa/

[60] Harm Reduction International. (2026). Integration of harm reduction services into primary health care centres in Indonesia. https://hri.global/publications/integration-of-harm-reduction-services-into-primary-health-care-centers-in-indonesia/