

1.1 EXECUTIVE SUMMARY

The Global Harm Reduction Response

TABLE 1.1.1: Countries or territories employing a harm reduction approach in policy or practice

| Country or 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 | Peer distribution of naloxone | OAT in at least one prison | NSP in at least one prison |
|------------------------|--|---|---|------------------------------------|-------------------------------|----------------------------|----------------------------|
| ASIA | | | | | | | |
| Afghanistan | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ |
| Bangladesh | ✗ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Bhutan | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Brunei Darussalam | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Cambodia | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| China | ✗ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Hong Kong | ✗ | ✗ | ✓ | ✗ | ✗ | ✗ | ✗ |
| India | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ |
| Indonesia | ✗ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Japan | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Laos | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Macau | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Malaysia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Maldives | ✗ | ✗ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Mongolia | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Myanmar | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✗ |
| Nepal | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Pakistan | ✗ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Philippines | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Singapore | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| South Korea | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Sri Lanka | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Taiwan | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Thailand | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Vietnam | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ |
| EURASIA | | | | | | | |
| Albania | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^a | ✗ |
| Armenia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ |
| Azerbaijan | ✗ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Belarus | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Bosnia and Herzegovina | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Bulgaria | ✓ | ✗ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Croatia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Czechia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Estonia | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ |
| Georgia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^b | ✗ |
| Hungary | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^b | ✗ |
| Kazakhstan | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Kosovo | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Kyrgyzstan | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ |
| Latvia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^a | ✗ |
| Lithuania | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^a | ✗ |
| Moldova | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ |
| Montenegro | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^a | ✗ |

^a OAT cannot be initiated within the prison, but is available as a continuation of medication

^b OAT is available only for short detoxification but not for long term maintenance treatment

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|--|--|---|---|------------------------------------|-------------------------------|----------------------------|----------------------------|
| North Macedonia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ |
| Poland | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Romania | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Russia | ✗ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Serbia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^a | ✗ |
| Slovakia | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Slovenia | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Tajikistan | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ |
| Turkmenistan | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Ukraine | ✓ | ✓ | ✓ | ✗ ^c | ✓ | ✓ | ✗ |
| Uzbekistan | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| LATIN AMERICA AND THE CARIBBEAN | | | | | | | |
| Argentina | ✓ | ✗ | ✓ | ✗ | ✗ | ✗ | ✗ |
| The Bahamas | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Bolivia | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Brazil | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Chile | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Colombia | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Costa Rica | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Dominican Republic | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Ecuador | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| El Salvador | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Guatemala | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Guyana | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Haiti | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Honduras | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Jamaica | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Mexico | ✓ | ✓ | ✓ | ✗ ^d | ✓ | ✗ | ✗ |
| Nicaragua | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Panama | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Paraguay | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Peru | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Puerto Rico | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✗ |
| Suriname | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Uruguay | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Venezuela | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| MIDDLE EAST AND NORTH AFRICA | | | | | | | |
| Algeria | ✗ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Bahrain | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Egypt | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Iran | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Iraq | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Israel | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ |
| Jordan | ✗ | ✗ | ✗ | ✗ | ✗ | ✓ ^a | ✗ |
| Kuwait | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Lebanon | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ ^a | ✗ |

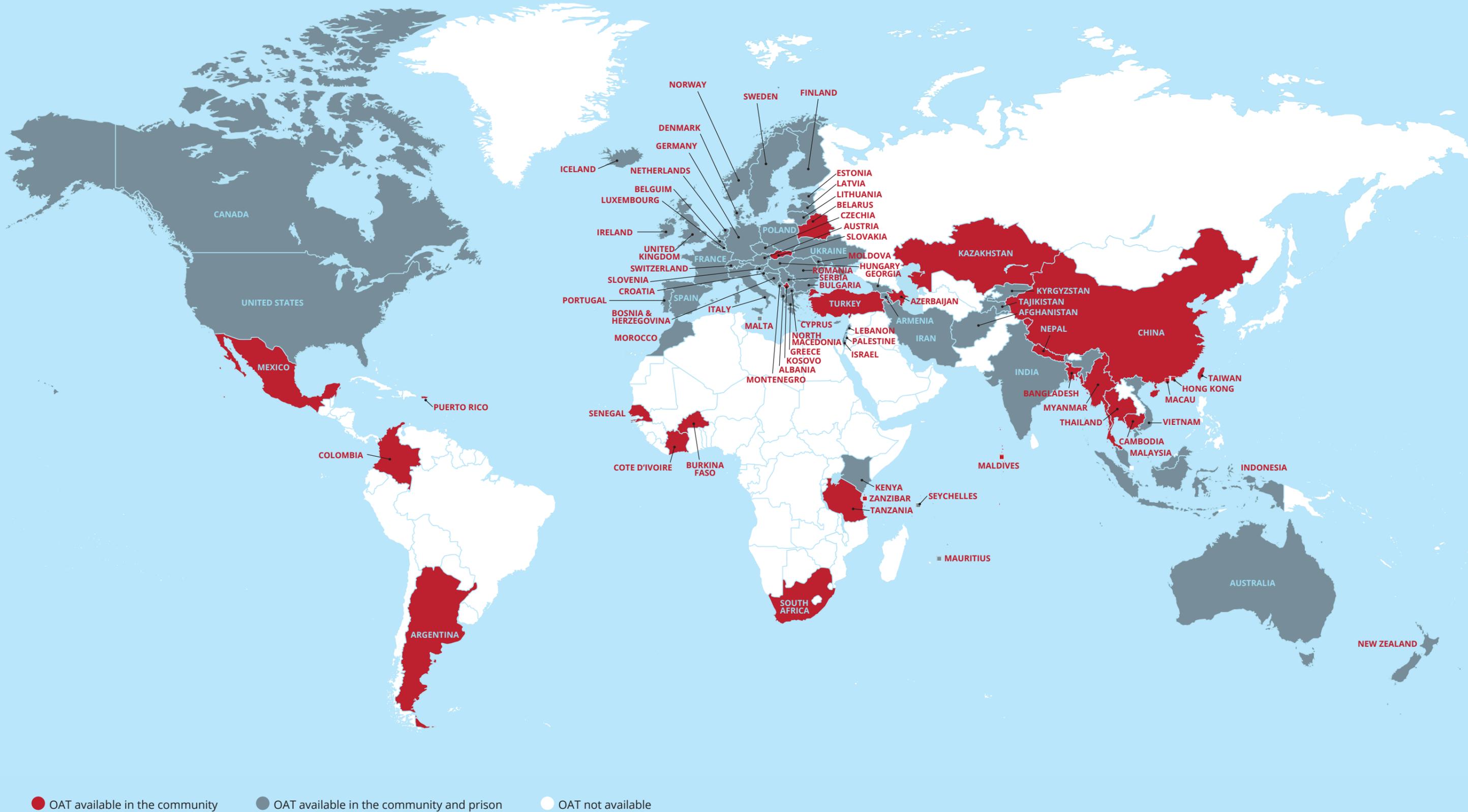
^c There is one harm reduction site that allows drug use on its premises, but it is not recognised officially as a DCR.

^d Though one DCR operates in Mexicali, Mexico, this is not officially sanctioned by the state.

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|--|--|---|---|------------------------------------|-------------------------------|----------------------------|----------------------------|
| Libya | x | x | x | x | x | x | x |
| Morocco | ✓ | ✓ | ✓ | x | x | ✓ ^a | x |
| Oman | ✓ | x | x | x | x | x | x |
| Palestine | ✓ | x | ✓ | x | x | ✓ | x |
| Qatar | x | x | x | x | x | x | x |
| Saudi Arabia | x | x | x | x | x | x | x |
| Syria | x | x | x | x | x | x | x |
| Tunisia | x | ✓ | x | x | x | x | x |
| UAE | x | x | x | x | x | x | x |
| Yemen | x | x | x | x | x | x | x |
| NORTH AMERICA | | | | | | | |
| Canada | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| United States | ✓ | ✓ | ✓ | x | ✓ | ✓ | x |
| OCEANIA | | | | | | | |
| Australia | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x |
| Fiji | x | x | x | x | x | x | x |
| Kiribati | x | x | x | x | x | x | x |
| Marshall Islands | x | x | x | x | x | x | x |
| Micronesia | x | x | x | x | x | x | x |
| New Zealand | ✓ | ✓ | ✓ | x | ✓ | ✓ | x |
| Palau | x | x | x | x | x | x | x |
| Papua New Guinea | x | x | x | x | x | x | x |
| Samoa | x | x | x | x | x | x | x |
| Solomon Islands | x | x | x | x | x | x | x |
| Tonga | x | x | x | x | x | x | x |
| Vanuatu | x | x | x | x | x | x | x |
| SUB-SAHARAN AND WEST AFRICA | | | | | | | |
| Angola | x | x | x | x | x | x | x |
| Benin | x | ✓ | x | x | x | x | x |
| Burkina Faso | x | x | ✓ | x | x | x | x |
| Burundi | x | x | x | x | x | x | x |
| Cameroon | x | x | x | x | x | x | x |
| Cape Verde | x | x | x | x | x | x | x |
| Central African Republic | x | x | x | x | x | x | x |
| Chad | x | x | x | x | x | x | x |
| Côte d'Ivoire | x | x | ✓ | x | x | x | x |
| Democratic Republic of the Congo (DRC) | x | x | x | x | x | x | x |
| Djibouti | x | x | x | x | x | x | x |
| Ethiopia | x | x | x | x | x | x | x |
| Gabon | x | x | x | x | x | x | x |
| Gambia | x | x | x | x | x | x | x |
| Ghana | ✓ | x | x | x | x | x | x |
| Guinea | x | x | x | x | x | x | x |
| Kenya | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Lesotho | x | x | x | x | x | x | x |

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|-----------------------|--|---|---|------------------------------------|-------------------------------|----------------------------|----------------------------|
| Liberia | x | x | x | x | x | x | x |
| Madagascar | x | x | x | x | x | x | x |
| Malawi | x | x | x | x | x | x | x |
| Mali | x | ✓ | x | x | x | x | x |
| Mauritius | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Mozambique | x | ✓ | x | x | x | x | x |
| Niger | x | x | x | x | x | x | x |
| Nigeria | ✓ | ✓ | x | x | x | x | x |
| Rwanda | x | x | x | x | x | x | x |
| Senegal | ✓ | ✓ | ✓ | x | x | x | x |
| Seychelles | ✓ | x | ✓ | x | x | ✓ | x |
| Sierra Leone | x | ✓ | x | x | x | x | x |
| Somalia | x | x | x | x | x | x | x |
| South Africa | ✓ | ✓ | ✓ | x | x | x | x |
| Tanzania | ✓ | ✓ | ✓ | x | x | x | x |
| Tanzania (Zanzibar) | ✓ | x | ✓ | x | x | x | x |
| Togo | x | x | x | x | x | x | x |
| Uganda | ✓ | x | x | x | x | x | x |
| Zambia | ✓ | x | x | x | x | x | x |
| Zimbabwe | x | x | x | x | x | x | x |
| WESTERN EUROPE | | | | | | | |
| Andorra | nk | nk | nk | x | nk | nk | nk |
| Austria | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Belgium | ✓ | ✓ | ✓ | ✓ | x | ✓ | x |
| Cyprus | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Denmark | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x |
| Finland | ✓ | ✓ | ✓ | x | x | ✓ | x |
| France | ✓ | ✓ | ✓ | ✓ | x | ✓ | x |
| Germany | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ |
| Greece | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Iceland | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Ireland | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Italy | ✓ | ✓ | ✓ | x | ✓ | ✓ | x |
| Luxembourg | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ |
| Malta | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Monaco | nk | nk | nk | x | nk | nk | nk |
| Netherlands | ✓ | ✓ | ✓ | ✓ | x | ✓ | x |
| Norway | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x |
| Portugal | ✓ | ✓ | ✓ | ✓ | x | ✓ | x |
| San Marino | nk | nk | nk | x | nk | nk | nk |
| Spain | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ |
| Sweden | ✓ | ✓ | ✓ | x | x | ✓ | x |
| Switzerland | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ |
| Turkey | x | x | ✓ | x | x | x | x |
| United Kingdom | ✓ | ✓ | ✓ | x | ✓ | ✓ | x |
| TOTALS | 87 | 86 | 84 | 12 | 16 | 59 | 10 |

MAP 1.2:
Global availability of Opioid Agonist Therapy (OAT)
in the community and in prisons



Executive Summary

1. Global Overview – behind the numbers

This is the seventh edition of the *Global State of Harm Reduction*, compiled in a year when public health was leading the news agenda around the world. COVID-19 and the related measures introduced worldwide continue to disrupt life as we know it. We have monitored harm reduction services working on the ground for the past two years, where possible. This year we added a new chapter dedicated to the impact of COVID-19 on harm reduction service delivery and people who use drugs. We have also added dedicated chapters on hepatitis C and tuberculosis (TB) to broaden the focus, in pursuit of a global health perspective.

According to the latest report from the United Nations Office on Drugs and Crime (UNODC), an estimated 11.3 million people inject drugs globally, while HIV prevalence is estimated to be 12.6% and hepatitis C prevalence 48.5% among this population. However, while 179 of 206 countries report some injecting drug use, 110 countries and territories worldwide have no data on its prevalence. This data gap highlights the need for more and higher quality data to inform our efforts to implement appropriate harm reduction services that can address public health issues, including HIV and hepatitis C, soft tissue infections, and overdose.

Harm reduction implementation has worsened since our last report in 2018, after having stalled since 2014. The number of countries where needle and syringe programmes (NSPs) remained level at 86, and the number of countries where opioid agonist therapy (OAT) is available decreased by two to 84. There are also large differences between the regions in terms of harm reduction implementation: while NSPs and OAT are available in most countries in Eurasia, North America and Western Europe, these core harm reduction interventions are severely lacking in the majority of countries in other regions. An unfavourable drug policy environment hinders harm reduction service implementation in many countries across Asia, Latin America and the Caribbean, the Middle East and North Africa (MENA), and sub-Saharan Africa. Several countries have adopted more punitive drug strategies since the *Global State of Harm Reduction* last reported in 2018, including Bangladesh, Brazil and Sri Lanka.

Even where harm reduction services are available, there is often insufficient coverage and quality, or a lack of access to these services. Significant geographical gaps and an uneven

distribution of services exist even in countries pioneering harm reduction or in countries where harm reduction has been available for decades. Rural communities are particularly underserved in many countries and regions. In addition to the geographical gaps in coverage, there are sub-groups of people who use drugs that experience barriers in access because harm reduction services aren't tailored to their unique needs. These groups include women who use drugs, men who have sex with men, people who use stimulants and/or non-injecting methods, and people experiencing homelessness.

Overarching structural problems also negatively affect access to services. Criminalisation, racism and discrimination against Indigenous, Black and brown people results in low household incomes, unemployment, food insecurity, poor housing and lower levels of education. This, in turn, results not only in worse health outcomes for these communities but also in people from these communities disengaging or actively avoiding health services.

Women who use drugs are still frequently overlooked despite the complex harms, stigmatisation and structural violence they face. A substantial increase in gender-sensitive services is necessary to appropriately address their needs.

For all people who use drugs, stigma and discrimination are public health issues creating barriers precisely where more support is needed. Harm reduction services are equipped to address these gaps, as non-judgmental, community-based service delivery is among the core principles of harm reduction.

Despite the grave situation in the context of the global COVID-19 pandemic, this year brought some examples of important positive changes that could serve as evidence for the feasibility of less restrictive service delivery. OAT regulations were eased, longer take-home periods were allowed, and easier initiation and provision in community settings were introduced – all without any increase in diversion or overdoses. These cases – explored further in the COVID-19 Chapter 1.2 – prove that such initiatives, which the harm reduction community have long advocated for, are realistic, feasible goals that not only lead to a better quality of life for people who use drugs, but result in better public health outcomes overall.



For people who use drugs, stigma and discrimination are public health issues creating barriers precisely where more support is needed. Harm reduction services are equipped to address these gaps, as non-judgmental, community-based service delivery is among the core principles of harm reduction.



AN ESTIMATED
11.3
MILLION
PEOPLE INJECT DRUGS GLOBALLY

HARM REDUCTION IMPLEMENTATION HAS WORSENERD SINCE OUR LAST REPORT IN 2018, AFTER HAVING STALLED SINCE 2014.



THE NUMBER OF COUNTRIES WHERE NEEDLE AND SYRINGE PROGRAMMES ARE AVAILABLE REMAINED LEVEL



THE NUMBER OF COUNTRIES WHERE OPIOID AGONIST THERAPY IS AVAILABLE DECREASED BY TWO

2. Developments in harm reduction implementation



2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

The number of countries with NSPs implemented has remained level since the *Global State of Harm Reduction 2018*. As of 2020, 86 countries globally have at least one NSP, though on the ground this has meant NSP closures and openings in several countries since 2018. Algeria opened NSPs in the Middle East and North Africa region, but in Palestine and Jordan, NSPs stopped completely; in Asia, NSPs closed in Mongolia; in sub-Saharan Africa, NSPs opened in Benin, Nigeria and Sierra Leone, while in Uganda NSPs ceased to operate. Eurasia, North America, Oceania and Western Europe remained the regions where almost all countries with reported injecting drug use implemented NSPs.^[1]

The availability of NSPs, however, does not ensure adequate coverage and accessibility. There is a large disparity in NSP implementation globally. While NSPs in Australia distribute almost 700 syringes per person who injects drugs per year, in Benin in sub-Saharan Africa, only ten syringes are given in a month to a client visiting the programme.² In Macau, Asia, the number of NSPs has decreased since 2018, and only one NSP is still open. While NSPs are available in the majority of countries in Eurasia, there are several countries where coverage is very limited as services are implemented solely on a volunteer basis.^[3,4] New estimates from India suggest that just 35 syringes (down from 250) are distributed per person who injects drugs, despite an increase in the number of NSP sites in the country. Coverage could also vary within a country. In Western Europe, for example, the coverage of NSPs in urban areas is sufficient and there are no major barriers in access, but rural areas have less coverage in many countries (e.g. Austria, Belgium, the Netherlands, Germany and Portugal).^[5-9] Rural populations are also underserved in both the United States and Canada, and an uneven geographical distribution of NSPs is a problem in Australia and New Zealand.^[10,11]

Stigma and discrimination against people who inject drugs continue to exist and hinder service access in all contexts,^[12-15] affecting organisations implementing NSPs. In South Africa, for example, one NSP was closed in 2018 due to concerns of insufficient stakeholder consultation and the systems available for waste management.^[17] Though the service was reinstated in late June 2020, programme staff have yet to reach the previous cohort of clients that had accessed the service before its closure.^[18]

In addition to geographical gaps and stigmatisation of people who inject drugs, there are groups of people who inject drugs that experience barriers to access. The lack of appropriate, gender-specific programmes for women who use drugs is a recurring issue throughout most regions. Furthermore, the needs of Indigenous people are not appropriately met in Oceania,^[10,11] and there are reports of migrants who inject drugs facing barriers to accessing harm reduction services in Western Europe.^[6,9,19] NSP provision for people who use stimulants is suboptimal in many regions despite the risks involved. In Western Europe, for example, stimulant injecting has been associated with local HIV outbreaks in five countries in the past five years.^[20-22]



2.2 OPIOID AGONIST THERAPY (OAT)

The number of countries in which OAT is available has decreased since 2018, from 86 to 84. Three countries (Costa Rica, Bahrain and Kuwait) stopped OAT provision. In Costa Rica, prescription opioids are only used as pain relief for people in palliative care. In Bahrain, the OAT pilot programme highlighted in the *Global State of Harm Reduction 2018* has ceased to operate, and both Bahrain and Kuwait are among those countries where legal and technical barriers (related to methadone import and storage) hinder provision. OAT has been introduced in one country since 2018, Burkina Faso, where methadone is now listed as an essential medicine and delivered in a hospital setting in one addictions department.^[23]

The most frequently prescribed OAT medications have not changed since the last report. Methadone continues to be the most commonly prescribed substance where OAT is available, followed by buprenorphine or buprenorphine-naloxone. Long acting subcutaneous and subdermal formulations of buprenorphine are also available in some regions, for example it has been introduced in Australia and became available from April 2020.^[10,24] Heroin-assisted treatment (HAT) using diamorphine (also known as pharmaceutical heroin) is available in six countries in Western Europe (Denmark, Germany, Luxembourg, the Netherlands, Switzerland and the United Kingdom), and in Canada.

2 WHO has set NSP coverage target to 300 syringes per person who injects drugs per year to reach hepatitis elimination goals by 2030.^[2]

OAT provision is insufficient in many regions. OAT is now available in eight out of 49 countries with reported presence of injecting drug use in the sub-Saharan Africa region. OAT remains unavailable in Zimbabwe and Nigeria, despite significant populations of people who inject opioids and high HIV prevalence in both countries. In Latin America and the Caribbean, OAT is only available in Argentina, Colombia, Mexico and Puerto Rico, and it is increasingly administered in abstinence-focused settings rather than harm reduction ones.^[25-28]

Even where OAT is available, significant barriers exist in the accessibility of OAT for certain communities. Women, the transgender community, and people experiencing homelessness all face significant barriers to access in all regions. There is a lack of tailored services for women, Indigenous communities and young people in Canada,^[13,14] while young people who use drugs were reported as a subpopulation for whom OAT is unavailable in Switzerland.^[29]

Cost was reported as a serious barrier in access to OAT in many countries. For example, in Mexico, OAT is available only in private clinics at a high cost to the client; high dispensing fees are hindering access to OAT in Australia; and in Lebanon, OAT clients have to pay for the mandatory urine tests out of pocket, generating a serious financial burden for clients. Similarly to NSP implementation, uneven geographical distribution of OAT provision is a problem in almost every region, with rural areas especially underserved.



2.3 AMPHETAMINE-TYPE STIMULANTS (ATS), COCAINE AND ITS DERIVATIVES, AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Stimulants, including amphetamine-type stimulants (ATS, such as methamphetamine and MDMA) and cocaine and its derivatives, are widely used around the world. After cannabis, ATS are the second most commonly used substances globally. Among stimulants, amphetamine and methamphetamine are the most prevalent stimulants in MENA and sub-Saharan Africa, and cocaine is the most used stimulant in North America, Latin America and the Caribbean, Oceania and Western Europe. Growing prevalence of new psychoactive substances (NPS) was reported in Eurasia and Asia, while NPS use increased among young people in Latin America,^[1,30] and NPS use is disproportionate among marginalised populations in Western Europe.^[31-33]

Few stimulant-specific harm reduction responses are implemented globally. Though NSPs and drug consumption rooms (DCRs) can be accessed by people who use stimulants, existing harm reduction services might not always be adequate for their needs.^[34] For example, stimulant use is associated with more frequent injection than opioids, but limits in NSPs on the number of syringes that can be acquired at any one time represent a particular barrier for those injecting stimulants. Stimulants are also more likely to be smoked or inhaled than opioids, but not all DCRs permit inhalation on premises, and smoking equipment is rarely distributed. However, safer smoking kits for crack cocaine, cocaine paste and ATS are distributed in several territories, including Portugal^[5] and Puerto Rico.^[35] and harm reduction programmes for people who use non-injectable cocaine derivatives are in place in several countries in Latin America. There have been promising pilot programmes in Asia focusing on people who use methamphetamine, including outreach programmes distributing safer smoking kits, plastic straws, harm reduction education, and access to testing and treatment for HIV, hepatitis C, TB and other sexually transmitted diseases (see page 75 in Asia Chapter 2.1).

Drug checking (services that enable people to voluntarily get the contents of their drugs analysed) is an important harm reduction intervention for people who use stimulants. These services are implemented in at least nine countries in Western Europe³, are available in the United States, Australia and New Zealand, and are increasingly available in

³ Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom

Latin America⁴. Eight countries in Eurasia⁵ have some form of drug checking services through distribution of reagent test kits at music festivals and nightlife settings. Other methods of drug checking include the use of mobile testing equipment to determine the contents of what is sold using tiny samples of the product, allowing for identification of both drugs and contaminants. Though availability of drug checking is growing globally from a low baseline, implementation faces serious legal barriers in many countries as it involves handling controlled substances, and drug checking services often require formal exemption from drug laws in order to operate legally.

No approved substitution therapy for ATS exists, although pharmacologically-assisted treatment with methylphenidate for ATS users was authorised by the government in Czechia during the COVID-19 pandemic, and in Canada, the British Columbia Centre on Substance Use released interim clinical guidance recommending the prescription of dexamphetamine and methylphenidate to people who use stimulants.^[36]



2.4 OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

DCRs, also known as safe injecting facilities or safe injecting sites (SIFs/SISs), are professionally supervised healthcare facilities where people can consume their own drugs in a safe environment. DCRs are key interventions to prevent overdose deaths, as well as to reduce transmission of HIV and viral hepatitis and soft tissue infections.^[37] These services attract populations who may generally use drugs in higher-risk conditions, and reduce morbidity and mortality by providing a safe environment and training people on safer drug use.

The number of countries where DCRs are officially implemented⁶ has increased since 2018, with Portugal opening a mobile service in 2019.^[5,38] Globally, there are a total of 12 countries in three regions where DCRs operate: Australia, Canada, Belgium, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Portugal, Spain and Switzerland. Canada has the highest number of DCRs in

the world, 40 (up from 24 in 2018). In addition, at least 20 primarily volunteer-run and funded overdose prevention sites have been opened in the country.^[13] There are two DCRs in Australia, the second facility opened in 2018 in Melbourne, and an independent review of the first 18 months of its operation found that the DCR reduced harms for service users, and the provision of complex services was beneficial in providing access to other health and support services.^[39] There are at least 88 DCRs in Western Europe, where these services increasingly include supervised inhalation spaces alongside those for injecting, in order to adapt to the needs of people who smoke drugs and the decline in injecting in some contexts.^[40]

Naloxone distribution is another intervention addressing opioid overdose. Naloxone is a highly effective opioid antagonist used to reverse the effects of an opioid overdose in minutes, and can be delivered in various ways (intra-nasal, sublingual and buccal). It can, however, only be effective if it is accessible.^[41] In 2014, the World Health Organization (WHO) recommended that naloxone be made available to anyone likely to witness an opioid overdose.^[42] In an evaluation of community-based opioid overdose prevention, researchers found 83% to 100% survival rates among those who experienced an overdose and received naloxone, demonstrating that non-medical bystanders trained in community-based opioid prevention techniques were able to effectively administer naloxone.^[41]

Despite international recommendations and scientific evidence, naloxone is available only in medical, emergency or treatment settings in many countries. The restrictive legal environment remains a serious barrier to the implementation of naloxone distribution programmes. However, there are a few countries in every region where naloxone is available. For example, in the MENA region, naloxone is available in Iran at overdose prevention programmes and in take-home form (where people who use drugs or anyone likely to witness an opioid overdose can get and carry naloxone). In Latin America and the Caribbean, there is a peer distribution network of naloxone in northern Mexico, and naloxone became available in Puerto Rico after a long advocacy campaign by civil society. Afghanistan, India, Myanmar and Vietnam are the only four countries in Asia which have some form of naloxone distribution in operation. Naloxone is available in several countries in Eurasia, however Ukraine is the only country in

⁴ Drug checking is currently available in at least three countries: Colombia, Peru and Uruguay

⁵ Slovenia, Hungary, Estonia, Czechia, Lithuania, Ukraine, Georgia and Poland

⁶ Only DCRs officially sanctioned by the state are included here. There are 'underground' DCRs around the world; we decided not to include them because listing such DCRs could expose them, attract opposition and hinder their efforts.

the region where naloxone is available without prescription. In sub-Saharan Africa, naloxone remains largely unavailable or difficult to access. The peer distribution of naloxone, whereby individuals can pass on naloxone without each recipient requiring a personal prescription, is available in 16 countries⁷ globally, up from 12 in 2018.



2.5 VIRAL HEPATITIS, TUBERCULOSIS (TB) AND HIV

Globally, the prevalence of hepatitis C antibodies among people who inject drugs is estimated to be 48.5%, hepatitis B surface antigens to be 8.3%, and HIV 12.6%.^[43] Scaling up of, and access to, harm reduction interventions (like NSP, OAT, naloxone distribution and community-based testing and treatment) are included among key measures in decreasing the prevalence of HIV and hepatitis in international and regional guidelines.^[44–47] People who inject drugs are particularly vulnerable to HIV and hepatitis viruses, but other groups, such as people who smoke opioids or stimulants, are also at greater risk than the general population.^[48,49] For example, sharing of pipes and higher-risk sexual practices among people who use stimulants are associated with increased hepatitis C infection.^[1,50,51]

There is significant regional variation in prevalence of blood-borne viruses among people who inject drugs. The early implementation of harm reduction approaches (such as NSPs and OAT), and the sustained harm reduction response is credited with maintaining low prevalence of HIV among people who inject drugs in Australia, New Zealand and Switzerland, among others.^[52–54] Seven out of the twelve countries globally on track to meet WHO hepatitis C elimination targets are in Western Europe.^[55] Conversely, hepatitis C prevalence among people who inject drugs remains high in Eurasia.^[56]

One of the most reported barriers to HIV and hepatitis C testing and treatment is placement of services in settings that are not appropriate to the needs of key populations, though cases of good practice exist. Hepatitis C services in Canada, for example, are often integrated into harm reduction services to increase accessibility for people

who use drugs.^[13] There are ‘one-stop’ clinics for women in India, offering HIV counselling, testing and treatment in harm reduction services alongside other health and gender-sensitive programmes.^[57] Restrictions still exist on access to hepatitis C treatment for those actively using drugs, despite evidence showing strong treatment benefit with current treatment regimens for such patients.^[58,59] Stigma and discrimination towards people who use drugs, as well as unstable housing, poverty, criminalisation and incarceration, continue to act as major barriers to people accessing testing and treatment in every region.

An important issue to consider for the future is that HIV prevention, treatment and care among people who use drugs has focused on the needs of people who inject drugs, and mainly on those who inject opioids. In Latin America, data shows that use of stimulant drugs has also been associated with higher risk of HIV transmission through unsafe sexual behaviours.^[60,61] Community-based programmes are an effective way to reduce the barriers to diagnosis and treatment for key populations beside people who use drugs, like transgender people and people experiencing homelessness.

People who use drugs represent a disproportionate number of TB cases and are at greater risk of developing more serious TB disease.^[62] People living with HIV who inject drugs are two to six times more likely to develop TB disease than the general population,^[63–65] and TB is the leading cause of mortality in this group.^[66] People who use drugs are overrepresented in prisons and custodial settings, where the risk of TB increases to twenty-three times that of the general population.^[67] However, data on people who use drugs and have TB is lacking at global, regional and national levels, leading to harm reduction programmes not including TB services, and TB programmes lacking outreach programmes aiming for people who use drugs.

⁷ Afghanistan, Australia, Canada, Denmark, Estonia, France, Italy, India, Mexico, Myanmar, Norway, Puerto Rico, Ukraine, the United Kingdom, the United States and Vietnam.



2.6 HARM REDUCTION IN PRISONS

The world prison population has grown by 24% since 2000, which is about the same as the estimated increase in the world's general population.^[68] Cannabis is the drug for which the most people are brought into contact with the criminal justice system globally, accounting for more than half of all drug offences.^[69] Yet cocaine-related offences are particularly prevalent across Latin America.^[70] It is estimated that 61% of people arrested globally for drug offences are arrested for drug possession for personal use.^[69] Imprisoning people for drug use is not only costly, but it is also demonstrably disproportionate and systematically discriminatory.^[71] Furthermore, punitive drug policies and the demonisation of people who use drugs have continued to result in mass incarceration and the overcrowding of jails in Asia, Latin America and the Caribbean, North America and sub-Saharan Africa.^[72,73]

Women are disproportionately sentenced for drug-related offences, and are particularly vulnerable to negative health and social outcomes once incarcerated.^[69] Criminal justice systems are often ill-equipped to address the unique needs of women because services and procedures are designed for men. Women also face discrimination and stigmatisation within the criminal justice system and by their families because of gender stereotypes.^[69] These gender stereotypes hold women to different standards than men, and result in greater stigma toward both drug use and incarceration.^[70]

People in prison settings are one of the most vulnerable groups facing barriers to treatment due to discrimination and stigma,^[69] while interruption of treatment due to incarceration or after release is also an issue. Ensuring access to testing and treatment services in prisons is a legally binding human rights obligation,^[74,75] and essential to protecting public health because people in prisons are more vulnerable to infections such as HIV, hepatitis C and TB than the general population.^[76] HIV and hepatitis C testing and treatment in prisons are widely available in Western Europe, North America, Australia and New Zealand, though stigma and a lack of confidentiality impede access in these regions too. In Eurasia, HIV testing and treatment are available in prisons in every country, while only five countries offer these for hepatitis C in all prisons. Asia, the Middle East and North Africa, Latin America and the Caribbean and sub-Saharan Africa are the regions where HIV and hepatitis service implementation is more

fragmented, with serious barriers to access. For example, in sub-Saharan Africa, HIV prevention programmes are rarely available in prisons and many people in prison settings with HIV are unable to access antiretroviral therapy (ART).^[77,78] However there has been a degree of progress in the MENA region where UNODC, in cooperation with local government agencies, implemented a prison HIV project in several countries which delivered HIV, hepatitis C, hepatitis B and TB counselling, testing and treatment services. The project included women's prisons, addressing the gender gap and limited services delivered to women in prisons (see page 124 MENA chapter).

Drug use is present in most, if not all, prison settings, with approximately one third of people in prisons worldwide estimated to have used drugs at least once while incarcerated.^[79] New psychoactive substances (NPS) use in prisons was reported by 22 countries across Western Europe and Eurasia, with most of those countries identifying synthetic cannabinoids as the main substance used.^[69,80] Injecting drug use also occurs in prisons. For example, 32% of recently imprisoned NSP clients reported injecting in prison in Australia,^[81] and in Uganda, evidence indicates that many people incarcerated for non-injecting drug use transition to injecting during their incarceration, and then continue to inject after release.^[82] In Latvia, new synthetic opioid use in prison has been linked to an increase in injection, syringe sharing and overdoses.^[83] Without appropriate access to sterile injecting equipment, injecting drug use in prison poses serious health risks; according to an Australian study (where there is no NSP in prisons), syringes in prison settings are reused an estimated 100 times.^[16] The number of countries where NSPs are available in prisons has not changed since the last report: there are still only 10 countries globally where this service is available in at least one prison setting and coverage and access remain inadequate in these settings. For example, in Germany, one syringe dispensing machine is installed in one women's prison in the country,^[84] in Canada only 25% of federal prisons are covered by NSPs, and significant barriers to access (lack of information about availability, limited confidentiality, high rejection rates from the programme) make the services largely unavailable in practice.^[13,14,85] However, Canada is also home to a significant development in this area: the world's first prison DCR opened in Alberta in June 2019.^[13] While this is a positive step, a DCR cannot be considered a replacement for an effective prison NSP.

There are large differences in OAT availability in prisons

between regions. In Western Europe, North America and Oceania, and most of Eurasia and MENA, some OAT is available in prisons. However, OAT in prisons is largely absent in Latin America, the Caribbean and sub-Saharan Africa. In 2020, 59 countries are providing OAT in at least one prison, five more than when we last reported in 2018. OAT availability in prisons does not mean accessibility, and the most typical barrier to access is that it is available only to those who had been on OAT prior to incarceration. People who are released from prison are particularly vulnerable to opioid overdose,^[86] making it essential that people in and those released from prison have access to naloxone. An evaluation of an overdose education and naloxone distribution project in San Francisco found that the majority of the respondents had never been trained to use naloxone outside prison, and one third used naloxone later to reverse an overdose.^[87] However, overdose prevention training and take-home naloxone programmes are implemented in prisons in only five countries in North America and Western Europe, though naloxone is not available in all prisons in these countries either. Estonia is a good example of how practice of implementation can hinder access to services. Naloxone training is only available upon release from prison in the country if requested, which rarely happens for fear of being denied parole as a consequence of intention to use drugs.



2.7 HARM REDUCTION AND THE COVID-19 PANDEMIC

At the time of writing, the COVID-19 pandemic is still ongoing and the consequences to people who use drugs and to harm reduction services are still unfolding. However, we closely monitored the situation in 2020, and collected information from each region on harm reduction service delivery during the pandemic.

It is important to highlight that people who inject drugs are a population vulnerable to COVID-19.^[88] They can have underlying medical conditions, including a higher prevalence of HIV and hepatitis C than the general population.^[43] Coinfection with tuberculosis is also a serious issue that increases their risks.^[88] Inadequate living conditions or homelessness could add to susceptibility. Lockdown measures combined with criminalisation and over-policing

have created a situation that further increased hardships for people who use drugs experiencing homelessness. Furthermore, people who use drugs may be less able or willing to adhere to quarantine and physical distancing measures in general, since they may need to seek out harm reduction services like NSPs and OAT programmes, or need to procure drugs to avoid withdrawal symptoms.^[88] COVID-19-related risks are increased for people who smoke or inhale drugs, as this type of administration is associated with pulmonary and respiratory problems.^[89] In the US, a recent review found that those with opioid use disorder are ten times more likely to contract COVID-19 than the general population, and nearly 30% more likely to die from COVID-19 than other patients diagnosed with the coronavirus.^[90, 128]

Peer networks were among the first to react to the pandemic, both in terms of practical guidance and in advocacy. Early in the pandemic, the International Network of People Who Use Drugs (INPUD) and Harm Reduction International (HRI) developed a statement in cooperation with civil society organisations to protect the health and human rights of people who use drugs in light of the COVID-19 crisis.^[91] INPUD, in collaboration with the European Network of People Who Use Drugs (EuroNPUD), were the first to develop guidelines for people who use drugs, available in 20 languages, and developed a set of harm reduction tips for people who use drugs for avoiding COVID-19.^[92, 93] Peers played a crucial role beyond advocacy during the pandemic, they contributed to service delivery and filling the gap in service provision with peer-to-peer syringe distribution, providing input for professionals working in harm reduction, and disseminating information to fellow people who use drugs.

The lockdown measures and physical distancing rules introduced during the pandemic seriously disrupted harm reduction service delivery. This exacerbates the harms to public health, as interruption of harm reduction services – whether through closures, staffing restrictions, decreasing coverage or reducing funds – can lead to a spike in HIV and hepatitis C infections.^[94] While harm reduction services in Western Europe, North America, and parts of Eurasia have been able, in general, to maintain a relatively good level of coverage, services in other regions suffered more serious disruptions. For example, a regional survey in Asia found that young key populations experienced delays in accessing HIV and harm reduction services.^[95] In Latin America, contact with harm reduction programmes

3. Funding for harm reduction

has been limited due to physical distancing and the already limited number of services available in most of the countries in the region. In the Middle East and North Africa (MENA) region, harm reduction services had to reduce the number of working days or close entirely in all countries in the region. In sub-Saharan Africa, OAT services were suspended in some countries during COVID-19 as take-home OAT is rarely available in the region, and travel to health facilities was restricted. In the United States, interruption of services from NSP to addiction treatment, combined with isolation and the way in which COVID-19 has overwhelmed health and emergency services, all contributed to an increase in overdose deaths in the country.^{[96][97]}

Despite calls from international actors urging governments to limit arrests, promote alternatives to punishment and incarceration, and urgently release people in prison charged or convicted for minor or non-violent offences, including drug offences,^[98,99] 25% of countries that implemented prison decongestion schemes explicitly excluded people detained for certain drug offences, regardless of whether they met other eligibility criteria.^[100] The inevitable effect was that many people who use drugs in prison did not benefit from these schemes and remain behind bars.

However, there were positive changes in service delivery during the pandemic. Most importantly, OAT regulations were eased in many countries. Out of the 84 countries where OAT is available, HRI identified evidence of 47 countries expanding take-home periods for OAT medications and 23 making distribution more accessible with home delivery or OAT distribution in outreach services. Nine countries expanded induction practices, including facilitated or rapid initiation.^[101] The COVID-19 crisis has also shown that harm reduction services can adapt quickly and effectively, and are able to adjust service delivery and integrate innovative methods. To compensate for decreased coverage, mail delivery of harm reduction equipment, and increased outreach activities were common, including provision of more services in low threshold and community settings. Phone or video consultations were introduced as a common tool in some settings to compensate for the reduced availability of services.

In 2018, the *Global State of Harm Reduction* reported that harm reduction funding in low- and middle-income countries amounted to USD 188 million,^[102] just 13% of the UNAIDS estimate for an adequate harm reduction response.^[103] This situation is unlikely to have changed dramatically in the past two years, but there have been some important developments with implications for harm reduction funding during this time.

The global COVID-19 pandemic poses a threat to the already precarious funding situation for harm reduction. In May 2020, INPUD and HRI called upon donors and governments to safeguard harm reduction funding, provide additional funding to help services adapt, and to invest in communities and community leadership to ensure sustainable harm reduction financing.^[104]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is still the largest donor for harm reduction and, in 2019, harm reduction advocates around the world joined calls for donors and governments to ensure a successful Global Fund replenishment. More than 155 organisations and advocates signed onto the People Before Politics Call to Action.^[105] The USD 14 billion pledged to fight against AIDS, TB and malaria through 2021-2023 met the request made by the Global Fund in its investment case.^[106] and marked the largest amount ever raised by a multilateral health organisation.^[107] It fell short, however, of the amount advocates estimated necessary to meet global targets.^[108] The Call to Action also called for the safeguarding of Global Fund catalytic investments, which provide a vital lifeline for community-led and civil society advocacy for harm reduction.^[109]

Encouragingly, Global Fund HIV country envelopes (the amount allocated to countries for their HIV programmes, based on country income status, disease burden and a 'qualitative adjustment' process intended to take into account other factors) have increased for the majority of countries with high harm reduction need that are eligible for Global Fund support. However, this does not necessarily translate into an increase of funding for harm reduction. Decisions within Country Coordinating Mechanisms will determine the extent to which harm reduction funding is requested within grant applications, which is where poor political support for harm reduction and a lack of community representation remain a concern.^[110] In March 2020, to support the development of country grant proposals,^[111] the Global Fund published updated guidance on harm reduction and people who use drugs.

At the time of writing, harm reduction appears to have lost a major international donor with the Dutch Ministry of Foreign Affairs not renewing its bilateral support, under the auspices of a shift in funding priorities from HIV to sexual and reproductive health. A global leader for ensuring the health and human rights of people who use drugs, the Netherlands had been lauded for its commitment among a shrinking cohort of bilateral harm reduction donors. In July 2020, the harm reduction and drug policy sectors sent an urgent appeal to the Dutch Minister of Foreign Trade and Development Cooperation to recommit the brave and long-standing political and financial support for the health and rights of people who use drugs.^[112]



25% of countries that implemented prison decongestion schemes explicitly excluded people detained for certain drug offences, regardless of whether they met other eligibility criteria.^[100]

Harm reduction and the next global AIDS strategy



The development of the 2021-2025 UNAIDS strategy marks another important moment for harm reduction. This will serve as a roadmap for the world to end AIDS by 2030 as enshrined in the Sustainable Development Goals and will include new targets and resource needs estimates. The world has failed to meet most of the UNAIDS 2020 targets and the majority of new HIV infections are now among key populations, including people who use drugs, and their sexual partners.

It is therefore crucial that the new global AIDS strategy upholds and strengthens the rights of people who use drugs and gives due priority to harm reduction. This message was taken to the UNAIDS Programme Coordinating Board (PCB) in September 2020 by 33 civil society and community-led organisations. They called on the PCB to ensure that key populations, including people who inject drugs, are prioritised in the new global AIDS strategy; harm reduction services are available, scaled-up and fully funded to meet the HIV prevention and health needs of people who use drugs wherever needed; communities, including community-led services, and civil society are at the front and centre of the HIV response; and barriers to services, including criminalisation, stigma, discrimination, punitive laws and policies, are removed.^[113] This prompted a positive response from UNAIDS Executive Director, Winnie Byanyima, outlining her commitment to ‘ensuring that the entire Joint United Nations Programme on HIV/AIDS, donors, Member States and other actors are accountable in implementing commitments under this new strategy and in defending the human rights of people who use drugs.’

The new global AIDS strategy will have profound implications - either by compounding or alleviating the political invisibility of people who use drugs. The strategy will directly influence the development of the 2021 Political Declaration on HIV and AIDS and member states’ commitment to ending AIDS, including among people who use drugs. It will also directly inform the next Global Fund strategy which will determine the priorities of donors and governments in the years to follow.

4. International commitments on harm reduction and human rights

There have been a number of important developments on harm reduction and human rights at the international level since 2018, with drug laws and policies increasingly scrutinised through a human rights lens, and significant efforts undertaken to help ensure human rights compliance in the design and implementation of international drug control.

A clear signal was given by the 2019 Ministerial Declaration adopted during the 62nd UN Commission on Narcotic Drugs. Governments acknowledged the shortcomings of the current drug control strategy, including the fact that ‘health services continue to fall short of meeting needs and deaths related to drug use have increased’ - and reiterated the need for drug laws and policies to respect international human rights obligations.^[114]

The Declaration came just weeks after the adoption of the ‘UN System Common Position on supporting the implementation of the international drug control policy through effective inter-agency cooperation’ (*UN Common Position*). With this unprecedented document, all 31 UN agencies and entities agreed on a shared vision for drug control, committing to ‘supporting Member States in developing and implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented, and sustainable responses to the world drug problem.’ Among other commitments, the UN system pledged to ‘promote the increased investment in measures aimed at minimising the adverse public health consequences of drug abuse, by some referred to as harm reduction, which reduce new HIV infections, improve health outcomes and deliver broader social benefits by reducing pressure on health-care and criminal justice systems.’^[115]

The UN Common Position also established a dedicated UN Coordination Task Team, entrusted with ensuring coherent efforts are undertaken to realise the above-mentioned shared commitments. In March 2019, the Task Team published a sobering report on the state of drug control which also denounced the lack of evidence-based health services for people who inject drugs in many parts of the world.^[116]

Another landmark development was the launch, in March 2019, of the International Guidelines on Human Rights and Drug Policy, jointly developed by the International Centre on Human Rights and Drug Policy at the University of Essex and the UN Development Programme (UNDP), and co-sponsored by UNAIDS, the UN Office of the High Commissioner for Human Rights (OHCHR) and WHO. The result of a broad consultative process involving UN agencies, policymakers, academics and experts, the guidelines spell out a clear set of international standards to help maximise human rights protections in the design and implementation of drug control laws and policies.^[117] In the first eighteen months since their adoption, the guidelines have been used as a reference by UN Treaty Bodies, UN Special Procedures, national courts, advocacy papers, amicus briefs and other litigation efforts around the world.

In line with increasing concern about drug control on human rights, multiple human rights bodies have scrutinised states’ efforts to respect and promote the human rights of people who use drugs, including the right to essential harm reduction services. For example, the Human Rights Council, in its 41st Session, adopted a rare country-specific resolution expressing concern for human rights violations unfolding in the Philippines in the context of President Duterte’s repressive anti-drug campaign, and requested the UN High Commissioner for Human Rights report on the situation.^[118]

The High Commissioner also drew attention to the impact of punitive drug control on human rights. For example, in a 2019 report on violence, death and serious injury in situations of deprivation of liberty, the Commissioner denounced serious human rights violations endured by people who use drugs in detention settings, including torture and ill-treatment, intentional withholding of drug treatment as a form of punishment, and lack of adequate healthcare in detention.^[119]

Similarly, the UN Committee on Economic, Social and Cultural Rights reiterated concerns for the criminalisation of drug use and drug possession, noting its negative impact on access to harm reduction services;^[120,121] denounced the continued stigmatisation of people who use drugs and the limited access to harm reduction services in prisons;^[122] and condemned regional disparities in availability and accessibility of harm reduction services.^[123]

Finally, the UN Special Rapporteur on the right to health continued to clarify states’ obligations vis-à-vis people

5. Technical guidance

who use drugs. For example, the Rapporteur denounced the impact of xenophobia and intolerance on access to harm reduction services,^[124] and warned of the risks of purely biomedical approaches to drug use, explaining that they “can reflect parallel coercive practices, detention, stigmatisation and the lack of consent found in criminalised approaches.” As a consequence, “without human rights safeguards, these practices can flourish and can often disproportionately affect individuals who face social, economic or racial marginalisation.”^[125]

This attention to the rights of people who use drugs was renewed in April 2020, when the Special Rapporteur, with the support of seven other UN Special Rapporteurs, published a statement on the protection of people who use drugs during the COVID-19 pandemic. After acknowledging the unique needs and risks faced by people who use drugs in this context, the UN expert provided detailed guidance on how to ensure fundamental rights are protected during the pandemic. Among others, states were urged to ensure access to harm reduction services and controlled medicines, safeguard gender-sensitive harm reduction services, protect people experiencing homelessness, address prison overcrowding, and safeguard the health of people in prison.^[126]

As forcefully reiterated by the High Commissioner for Human Rights, Michelle Bachelet, in her keynote speech at the 2019 Harm Reduction International Conference in Porto (Portugal), it is now clearer than ever that “people do not lose their human rights because they use drugs”, and that “government policies should not become a greater threat to their wellbeing than the drugs which they are using.”^[127]

- In January 2019, the International Network of People who Use Drugs and the Asian Network of People who Use Drugs published a language statement and reference guide under the title *Words Matter!*^[129]
- In March 2019, the World Health Organization, the United Nations Development Programme, UNAIDS and the International Centre on Human Rights and Drug Policy published guidelines under the title *International Guidelines on Human Rights and Drug Policy*.^[130]
- In April 2019, the World Health Organization published a policy brief titled *Access to hepatitis C testing and treatment for people who inject drugs and people in prisons – a global perspective*.^[131]
- In August 2019, the United Nations Office on Drugs and Crime, World Health Organization and UNAIDS published a joint technical guide under the title *HIV prevention, treatment, care and support for people who use stimulant drugs*.^[132]
- In September 2019, the European Monitoring Centre for Drugs and Drug Addiction published a technical report titled *Monitoring the elimination of viral hepatitis as a public health threat among people who inject drugs in Europe*.^[133]
- In September 2019, the International Network of People who Use Drugs published a technical brief titled *What does Universal Health Coverage mean for People who Use Drugs*.^[134]
- In October 2019, the Global Fund published a technical brief titled *Programming at scale with sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prison and other closed settings*.^[135]
- In March 2020, the Global Fund published a technical brief titled *Harm Reduction for People who Use Drugs*.^[111]
- In April 2020, the United Nation Office on Drugs and Crime published recommendations on *COVID-19, HIV prevention, treatment, care and support for people who use drugs*.^[136]
- In March 2020, the European Monitoring Centre for Drugs and Drug Addiction released an ad hoc publication under the title *EMCDDA update on the implications of COVID-19 for people who use drugs and drug service providers*.^[137]
- In June 2020, PEPFAR, USAID, EpiC, UNAIDS and the Global HIV Prevention Coalition published a strategy titled *Strategic considerations for mitigating the impact of COVID-19 on key-population-focused HIV programs*.^[138]
- In August 2020, UNAIDS published a report *Rights in a pandemic – Lockdowns, rights and lessons from HIV in the early response to COVID-19*, which outlines 10 immediate areas for action for governments towards building effective, rights-based COVID-19 responses.^[139]

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