

Submission to the Office of the High Commissioner on Human Rights (OHCHR) on

Human rights in the context of HIV/AIDS, pursuant to HRC Resolution 47/14

16 February 2022

Submitting organisations:



Harm Reduction International (HRI) is a leading non-governmental organisation dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.



The International Drug Policy Consortium (IDPC) is a global network of 192 non-government organisations, established in 2006, advocating for drug policies that are based on evidence and principles of public health, human rights, human security and development.



The **Centre on Drug Policy Evaluation (CDPE)** works collaboratively with governments, affected communities, and civil society to improve community health and safety by conducting research and outreach on effective and evidence-based policy responses to substance use



Instituto RIA is a Mexican based organization that undertakes high quality research, highlighting and proposing innovations in order to advocate for public policies within a social justice framework. Human rights, access to justice, and peace building, stand at the center of our analysis, proposals and advocacy work, opening dialogue and debate , publishing evidence-based research, and catalysing innovative initiatives in Latin America to the international level.

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Introduction

HRI, IDPC, CDPE and Instituto RIA welcome the opportunity to contribute on “actions taken and to be intensified or initiated to meet the innovative targets on societal enablers (*hereinafter: societal enablers targets*) [...] and to address the remaining gaps”; ahead of the High Commissioner’s report on human rights in the context of HIV/AIDS to be presented at the Human Rights Council in its 50th session.

This submission focuses on **drug control policies and people who use drugs**. In 2018, around 269 million people used drugs and 11 million injected drugs,¹ of whom 1.4 million living with HIV.² The risk of acquiring HIV for people who inject drugs is 35 times higher than for people who do not.³ While incidence of HIV infection globally declined by 23% between 2010 and 2019, HIV infections among people who inject drugs increased in Eastern Europe and Central Asia, Asia, Middle East and North Africa.⁴ In 2019, only 62% of people who inject drugs were aware of their HIV status;⁵ well below the 95-95-95 target.

People who use drugs are criminalised and among the most marginalised, stigmatised, underserved groups in many countries, and experience a wide range of human rights violations and abuses, often as result of punitive laws and policies; which put them at heightened risk of HIV transmission. It will thus be impossible to achieve the societal enablers target without comprehensive drug policy reform and meaningful participation of people who use drugs. The following paragraphs provide information on key drug policy-related barriers to achieving the societal enablers targets.⁶

1_Punitive drug policies

People who use drugs are criminalised and marginalised in most countries, resulting in significant barriers to accessing health (including HIV) services, as well as to the enjoyment of fundamental rights. Notably, criminalisation of drug use and related activities is proven to have a negative effect on HIV prevention and treatment.⁷ For a comprehensive analysis of this issue and related recommendations, we refer to and endorse IDPC’s submission “The decriminalisation of people who use drugs: Evidence for a critical societal enabler to end AIDS”.

2_Laws and policies restricting the availability and accessibility of harm reduction and other health services

A key gap towards achieving the societal enablers targets is the lack of adequate harm reduction policies, and/or policies actively restricting the provision of essential harm reduction services at national level.

Harm reduction is endorsed by the 2021 Political Declaration on HIV and AIDS, actors including OHCHR, UNODC, UNAIDS, WHO, and the UN Common Position on drug policy; recognised as highly effective, cost-effective, and a key component of the right to health for people who use drugs. Nevertheless, the provision of harm reduction interventions is critically low, with **only one percent of people who inject drugs living in countries with high coverage**.⁸ In 2021, only 89 countries had national policy documents which included explicitly supportive references to harm reduction. In remaining countries, laws and policies are either silent – leading to uncertainty – or hindering service provision. Access to harm reduction and other health services is also impinged by laws/policies requiring identification documents to access services: in some regions many people who use drugs do not have such documents (in some cases because of homelessness or poverty),⁹ or are reluctant to

show them because they fear negative legal consequences.¹⁰ This is exacerbated in countries where laws require registration of people who use drugs;¹¹ in those contexts, drug use registration can translate into criminal sanctions, forced drug treatment, loss of social support and parental custody.

2.1 Harm reduction in prison

The legal and policy environment for harm reduction in closed settings is even more restrictive. As of 2021, Opioid Agonist Therapy (OAT) was only available in some prisons in 59 countries; Needle and Syringe Programs (NSPs) were only present in some prisons in 10 countries.¹² Women are further deprioritised, while facing additional stigma;¹³ for example, HIV treatment and NSPs are more widely available in male than in female prisons.¹⁴ Access to harm reduction in prison is further hampered by administrative barriers or restrictive access policies; for example, in several countries OAT in prison can only be accessed by people who were enrolled in an OAT programme in the community – meaning, OAT cannot be initiated in detention.¹⁵

2.2. Criminalisation of harm reduction

Particularly problematic are laws that directly or indirectly criminalise these services, including through criminalisation of possession of paraphernalia and equipment for drug consumption. In 2018, UNAIDS reported that in ten countries the mere “possession of a needle or syringe without a prescription could be used as evidence of drug use or cause for arrest.”¹⁶ Provision of OAT is prohibited in countries such as Russia and Turkmenistan.¹⁷ Similarly, in the Philippines, methadone and buprenorphine – the most commonly used medicines for OAT – are classified as dangerous drugs, thus possession and use are essentially criminalised.¹⁸

According to UNAIDS at least 21 countries’ policies exclude people who use drugs from receiving anti-retroviral treatment (ART), despite the lack of any health justification for it.¹⁹

2.3 Funding policies

Access to harm reduction for people who use drugs is severely hampered by inadequate funding policies. Although harm reduction services are proven and cost-effective protection from HIV and hepatitis C, HRI’s research identified a severe lack of financial support both for services and for the advocacy necessary to garner political will. 2019 data indicates that an estimated US\$131 million was allocated to harm reduction in low- and middle-income (LMI) countries, equating to just 5% of the US\$2.7 billion that UNAIDS estimates is required annually for harm reduction by 2025.²⁰ This equals a **95% funding gap – which is widening**.²¹ Two-thirds of LMI countries do not provide domestic resources to cover essential interventions such as HIV testing for people who inject drugs, OAT, NSPs, and overdose prevention programmes. In most LMI countries where domestic funding for harm reduction is in place, it is very limited.²² The Global Drug Policy Index, now scoring 30 countries, indicates that current investment in harm reduction is considered to be ‘mostly secure’ in just one country (Norway).²³

Also essential to meet the societal enablers targets is **community-led and civil society advocacy** for harm reduction and human-rights centred policies. Investing in communities is key to promote reform of restrictive policies, and reduce stigma and discrimination. It will also be crucial to meet the 2021 Political Declaration target of 60% of the programmes supporting the achievement of societal enablers to be delivered by community-led organisations.²⁴ Nevertheless, international and national funding for advocacy-related initiatives remains minimal, and largely insufficient.²⁵

This lack of funding is not inevitable, but rather the direct outcome of political choices on the distribution of resources, rooted in a predominantly punitive approach to drugs. Each year, over USD 100 billion is estimated to be spent on global drug law enforcement, over 750 times the amount

allocated to harm reduction services for people who use drugs.²⁶ A solution to this funding gap, which would be critical in meeting the societal enablers targets, would be the **redirection of funds from ineffective drug law enforcement to harm reduction**. Redirecting just a small proportion of drug law enforcement spending towards harm reduction would have a dramatic impact upon new HIV infections and make the global goal to end AIDS among people who use drugs by 2030 achievable.²⁷

3_Barriers faced by women who use drugs

An estimated 3.2 million women inject drugs worldwide, constituting around 20% of all people who inject drugs. Criminalisation is an almost insurmountable barrier for women who use drugs in accessing services, including Sexual and Reproductive Health (SRH) services; it causes and reinforces stigma and discrimination, including by healthcare providers; and it contributes to a lack of services focused on the specific needs of women who use drugs.

3.1 Lack of gender-sensitive health services

Where available, harm reduction services remain overwhelmingly gender-blind or male-focused, and do not integrate SRH services (including pregnancy tests, antenatal care, or other pregnancy-related services), leaving women underserved.²⁸ Although women who use drugs are disproportionately exposed to gender-based violence, harm reduction services often do not address gender-based violence, and are ill-equipped to adequately address the interaction between drug use and experiences of violence.²⁹ On the other side, services to address gender-based violence or protect women at risk sometimes exclude women on account of drug use.³⁰

Discrimination against women who use drugs in healthcare settings, including harm reduction and SRH services, is widespread, resulting in denial of services, provision of services of lesser quality, longer waiting periods, abuse.³¹ Further, women are reportedly more likely to be subjected to breaches of confidentiality when accessing harm reduction services.³² This issue is compounded by a lack of dedicated training of healthcare staff about drug use, HIV, and circumstances and needs of women who use drugs.³³ Fear of stigma and repercussions hinders women from communicating their drug use to healthcare professionals, leading to health interventions which are not tailored to their needs.³⁴

3.2 Coerced sterilisation and criminalisation of pregnant women who use drugs

Women who use drugs can experience pressure or coercion to adopt potentially irreversible methods of contraception. Campaigns that pressure women who use drugs to undergo sterilisation are reported in UK and US, rooted in stigmatisation and prejudice.³⁵ Coerced sterilisation of women living with HIV is reported in South Africa.³⁶ In countries such as Russia and Ukraine women who use drugs have been pressured to undergo abortions or relinquish their new-borns.³⁷

Punitive laws or attitudes perceive women who use drugs as either 'bad mothers' and/or **criminalise them for using drugs during pregnancy**.³⁸ In some contexts, drug use is in itself defined as a form of child abuse, while in others the stigmatisation surrounding it enables prejudiced evaluations of women's ability to care for their children. In Norway, women who use drugs during pregnancy can be incarcerated until they give birth or terminate their pregnancy.³⁹ Similarly, 'fetal assault laws' in US states criminalise drug use during pregnancy, allowing for arrest and prosecution. As of 2015, 45 US states had prosecuted women for using drugs during pregnancy, 18 sanctioned drug use during pregnancy as child abuse, 15 required healthcare workers to report drug use during pregnancy, and three forced pregnant women to undergo drug treatment.⁴⁰ These laws/policies are neither necessary nor proportionate to achieve public health goals; they violate the rights of both women and children,

and deter women who use drugs from seeking antenatal and postnatal care, as well as support when they experience violence or abuse.

4_Good practices

4.1 Integrated services

Integrated harm reduction services are sites/organisations that provide one or more ‘traditional’ harm reduction services alongside other health and social services, such as those seeking to address mental health, housing insecurity, or gender-based violence. They are effective from a health perspective, more accessible than traditional services, and cost-effective.⁴¹ For integrated services to realise their full potential, a key element is the leadership and involvement of people who use drugs in their design, management, and implementation.

With regard to women, research shows that integrating SRH services in harm reduction services, and promoting the active participation of women who use drugs in design, monitoring and provision of services, can be highly beneficial, enabling women who use drugs to access multiple services in one, non-judgmental setting where their specific needs are understood and addressed.⁴² In 2018, the Guttmacher-Lancet Commission on SRHR provided a new, comprehensive and integrated definition of SRHR, outlining components of SRHR that should be universally available;⁴³ all of the services identified therein can be incorporated into harm reduction services, and *vice versa*.

4.2 Local policies

Absent sustained investment and/or support by the national government, local authorities have in some cases introduced progressive policies and practices to expand access to harm reduction and other health services, and reduce criminalisation, stigma and discrimination against people who use drugs. One example is that of the city government of Liège, which recently opened the first drug consumption room in Belgium, without official authorisation by the national government. For more examples, we refer to HRI and Release submission to OHCHR on HRC Resolution 39/7 on Local Government and Human Rights.⁴⁴

¹ UNODC (2021), ‘World Drug Report 2021’ (Vienna: UNODC), <https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html>.

² Ibid., Booklet 2.

³ UNAIDS (2021), ‘Confronting Inequalities: Lessons for pandemic responses from 40 years of AIDS’ (Geneva: UNAIDS), https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf.

⁴ 43% in Eastern Europe and Central Asia, 18% in Asia, and 25% in the Middle East and North Africa. Ibid.

⁵ UNAIDS (2021), ‘HIV and People who Use Drugs’, https://www.unaids.org/sites/default/files/media_asset/02-hiv-human-rights-factsheet-people-who-use-drugs_en.pdf.

⁶ As defined in UNGA, ‘Political Declaration on HIV/AIDS’ (8 June 2021), para. 63(e), 65(a), 65(e).

⁷ Kora DeBeck et al (2017), ‘HIV and the criminalisation of drug use among people who inject drugs: a systematic review’, *The Lancet HIV* 4(8), E357 – E374.

⁸ Larney S et al (2017) ‘Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review’, *The Lancet Global Health* 5(12), e1208–e1220.

⁹ Among others, Bulgaria. See HRI and CHP Submission to UN Committee on Economic Social and Cultural Rights on Bulgaria (18 Jan 2019), <https://www.hri.global/contents/1891>.

¹⁰ Mouhebati, T ‘Sexual and Reproductive Health Services for People who Use Drugs’ (Amsterdam: AFEW and Mainline). https://mainline.blogbird.nl/uploads/mainline/Report_SRHR_Tatiana1.pdf

¹¹ Ibid.

¹² HRI (2021), ‘The Global State of Harm Reduction 2020’, https://www.hri.global/files/2021/03/04/Global_State_HRI_2020_BOOK_FA_Web.pdf.

¹³ For more information, see HRI (2021), See ‘Harm Reduction for Women in Prison’, https://www.hri.global/files/2020/06/10/Harm_Reduction_for_Women_in_Prison_2.pdf

- ¹⁴ Among others see: Gilbert L et al. (2001), 'Linking drug-related activities with experiences of partner violence: a focus group study of women in methadone treatment' *Violence Vict* 16, 517–36. El-Bassel; Stone, K and Shirley-Beavan, S (2018), 'Global State of Harm Reduction 2018', (London: HRI).; Pinkham S, Stoicescu C, and Myers B (2021), 'Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy' *Adv Prev Med* 2012:269123.
- ¹⁵ HRI (2021), 'The Harms of Incarceration', https://www.hri.global/files/2021/06/14/HRI_Briefing_Prisons_June2021_Final1.pdf.
- ¹⁶ UNAIDS (2018), 'Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices' (Geneva: UNAIDS), 54. https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf. Among others, this is the case in the Philippines and in US states: Possession of 'drug paraphernalia' is a crime in the Philippines, punished with imprisonment up to four years, and a fine. See Comprehensive Dangerous Drugs Act (2002), Section 12; Some US state laws envisage penalties for possession and distribution of drug paraphernalia; in Florida, for example, possession of drug paraphernalia can be punished with up to one year of jail.
- ¹⁷ Illegal acquisition, storage and distribution of these substances is a criminal offence, punishable with imprisonment between three and fifteen years.
- ¹⁸ NoBox Transitions Foundations, Inc (2018) Investment Into Harm Reduction In The Philippines. Report submitted to HRI within Harm Reduction Advocacy in Asia Global Fund Regional Project (unpublished). Available upon request.
- ¹⁹ See <https://lawsandpolicies.unaids.org/topicresult?i=248&lan=en>.
- ²⁰ Cook, C and Davies, C (2018), 'The Lost Decade: Neglect for harm reduction funding and the health crisis among people who use drugs' (London: HRI), <https://www.hri.global/files/2018/09/25/lost-decade-harm-reduction-funding-2018.PDF>.
- ²¹ Serebryakova, L, Cook, C and Davies, C (2021), 'Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries' (London: HRI), <https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF>. See also Ward et al (2022), 'Costs and impact on HIV transmission of a switch from a criminalisation to a public health approach to injecting drug use in eastern Europe and central Asia: a modelling analysis', *Lancet HIV* 9, e42–53.
- ²² Ibid.
- ²³ Funding was considered to be likely to be reduced in Canada, uncertain in New Zealand, Portugal and the United Kingdom, or somewhat unstable in Australia. For more details see 'The Global Drug Policy Index 2021' (Harm Reduction Consortium), p.48. <https://globaldrugpolicyindex.net/wp-content/themes/gdipi/uploads/GDPI%202021%20Report%20EN.pdf>
- ²⁴ UNGA, 'Political Declaration on HIV/AIDS' (18 June 2021), para. 64(e).
- ²⁵ Serebryakova, L, Cook, C and Davies, C (2021), 'Failure to Fund'.
- ²⁶ For more details, and country examples, see: HRI and HR Asia (2021), 'Divest. Redirect. Invest. The case for redirecting funds from ineffective drug law enforcement to harm reduction – spotlight on six countries in Asia', https://www.hri.global/files/2021/10/20/HRI_Briefing_Redirection_Oct_2021.pdf.
- ²⁷ See Harm Reduction International, 'Harm Reduction Decade', <https://www.hri.global/harm-reduction-decade>. Last accessed 03 Feb 2022.
- ²⁸ For more info, see HRI and WHRIN Submission to UN Working Group on discrimination against women and girls, 'Women's and girls' sexual and reproductive health and rights in situations of crisis' (30 August 2020), <https://bit.ly/3roaY6h>. Also Pinkham S, Stoicescu C, and Myers B (2012), 'Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy', *Adv Prev Med* 2012:269123.
- ²⁹ Malinowska-Sempruch K, (2015), 'What interventions are needed for women and girls who use drugs? A global perspective', *J Acquir Immune Defic Syndr*. 69 Suppl 2, S96-97. For example, women in Georgia report that the lack of services for people with experience of IPV is an unmet need in harm reduction services.²⁹
- ³⁰ Pinkham S, Stoicescu C, and Myers B (2012), 'Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy' *Adv Prev Med.*, 269123.
- ³¹ Wechsberg WM et al. (2015), 'Gender-specific HIV prevention interventions for women who use alcohol and other drugs: The evolution of the science and future directions.' *J Acquir Immune Defic Syndr* 69, S128–39.
- ³² HRI (2019) 'Women and Harm Reduction'. <https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf>.
- ³³ Among others, see Otiaashvili D et al., (2013) 'Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers', *International Journal of Drug Policy* 24, 566; Otiaashvili D et al. (2013), 'Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers', *International Journal of Drug Policy* 24, 566–72; Nyblade L et al. (2019), 'Stigma in health facilities: why it matters and how we can change it', *BMC Medicine*, 17:25.
- ³⁴ Mouhebati, T 'Sexual and Reproductive Health Services for People who Use Drugs'.
- ³⁵ Olsen, A, Banwell, C and Madden, A (2014), 'Contraception, punishment and women who use drugs', *BMC Womens Health*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3893510/>.
- ³⁶ Hu, S, 'Forced Sterilizations Devastates Lives in South Africa', <https://kennedyinstitute.georgetown.edu/showcase/wp-content/uploads/2020/04/Sonya-Hu-Bioethics-Forced-Sterilization.pdf>.
- ³⁷ The Global Coalition of Women and AIDS 'Women who use drugs, harm reduction and HIV', <https://idhdp.com/media/1114/brief-women-drugs-hiv-harm-final.Pdf>.
- ³⁸ International AIDS Society (2029), 'Women who inject drugs: Overlooked, yet visible', https://www.iasociety.org/Web/WebContent/File/2019_IAS_Brief_Women_who_inject_drugs.pdf.
- ³⁹ Soderstrom, K and Skolbekken, J A (2017), 'Pregnancy and substance use – the Norwegian z 10-3 solution. Ethical and clinical reflections related to incarceration of pregnant women to protect the foetus from harmful substances', *Nordic Studies on Alcohol and Drugs*, 155-171.
- ⁴⁰ Ibid. See also Propublica, 'How States Handle Drug Use During Pregnancy', <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>.
- ⁴¹ For more details and examples, see HRI (2021), 'Integrated and Person-Centred Harm Reduction Services', https://www.hri.global/files/2021/11/24/HRI_Integrated_Services_Briefing.pdf.
- ⁴² Among others, see: Stone, K and Shirley-Beavan, S (2018), 'Global State of Harm Reduction 2018', (London: HRI).
- ⁴³ These include services to address gender-based violence, HIV/AIDS and other STIs, contraception, maternal and newborn health, safe abortion and post-abortion care and cervical cancer testing and treatment. See: Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission (May 2018), <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>.
- ⁴⁴ Available at: <https://www.ohchr.org/EN/Issues/LocalGovernment/Pages/Index.aspx>, submission n.15.