Submission to the Special Rapporteur on Health Report on Drug Policies and Responses: a right to health framework on harm reduction

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Submitting organisation

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

HRI is an NGO in Special Consultative Status with the Economic and Social Council of United Nation.

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Introduction

Harm Reduction International (HRI) welcomes the opportunity to provide inputs ahead of the Special Rapporteur's report on "Drug Policies and Responses: A Right to Health Framework on Harm Reduction".

The provision of harm reduction is a human rights obligation, and it is understood as a comprehensive package of evidence-based interventions underpinned by public health and human rights, including policies, programmes and practices that aim to minimise the negative health, social, and legal impacts associated with drug use and drug policies. It encompasses a range of health, social and legal services and practices, including but not limited to information on safer use, drug consumption rooms (DCRs), needle and syringe programmes (NSPs), overdose prevention and reversal, opioid agonist therapy (OAT), housing, drug checking and legal and paralegal services[1].

This submission focuses on harm reduction for people who use drugs. Particularly, it draws on HRI's research on this topic and previous submissions, including the 2023 submission to the OHCHR pursuant to resolution 52/24 and the joint submission to the OHCHR on human rights in the context of HIV/AIDS, pursuant to HRC Resolution 47/14, dated February 2022. For information regarding harm reduction and people deprived of liberty, please see the joint submission to your office presented in this call for inputs.

Unless stated otherwise, all information provided in this submission refers to HRI's Global State of Harm Reduction 2022, and its 2023 updated briefing.

[1] Harm Reduction International. https://hri.global/what-is-harm-reduction/.

Question 1: Harm Reduction as a human right obligation and global overview

HRI has monitored the state of harm reduction around the world since 2008, where we report periodic updates of both services and policies in support of harm reduction. As of 2023, HRI has identified that:

- 109 countries have explicit positive reference to harm reduction in national policy[2];
- 92 countries implementing at least one NSPs[3];
- 88 countries with at least one OAT[4];
- 17 countries with legal and operational Drug Consumption Rooms (DCR)[5];
- 35 countries made take-home naloxone available[6];
- 23 countries operate peer-distribution naloxone programmes[7];
- 10 countries offer NSP in prisons[8]; and
- 59 countries make OAT available in prisons[9].

For the first time since 2014, HRI has found an increase in the number of countries implementing key harm reduction services.[10] This growth has been driven by new NSPs opening in five countries in Africa, as well as new countries having officially sanctioned drug consumption rooms DCRs.[11] Three countries have introduced OAT for the first time.[12] Unprecedently, the Global State of Harm Reduction (GSHR) 2022 has collected information on safer smoking and pharmacotherapy for people who smoke drugs

[2] 10 countries in Eastern and Southern Africa, 12 countries in Western and Central Africa, 20 countries in Western Europe, 26 countries in Eurasia, 14 countries in Asia, 15 countries in the Middle East and North Africa, 6 countries in Latin America and the Caribbean, 2 in North America and 4 in Oceania.

[3] Six more countries have implemented NSPs since 2020, namely Burundi, Cote d'Ivoire, Democratic Republic of the Congo, Guinea, and Uganda. Additionally, in Seychelles, NSPs have been available since 2016, but this was unreported in previous editions of the Global State of Harm Reduction.

[4] In 2023, Egypt commenced the implementation of OAT programmes.

[5] HRI acknowledges that the legal status of DCRs varies globally. The Global State of Harm Reduction includes in its count those facilities that have official backing from state authorities at either the national, sub-national or city level.
Since 2020, four more countries implemented DCRs, namely Greece, Iceland, Mexico and the United States. Colombia has recently launched a new drug consumption room in Bogota this year.

[6] Afghanistan, Albania, Aotearoa-New Zealand, Australia, Austria, Canada, Czechia, Cyprus, Denmark, Estonia, France, Germany, Georgia, India, Italy, Iran, Ireland, Kenya, Kyrgyzstan, Lithuania, Mexico, Myanmar, Moldova, Mozambique, Norway, Puerto Rico, Portugal, Slovenia, Spain, Sweden, South Africa, Tajikistan, Ukraine, United States of America, and United Kingdom.

[7]Afghanistan, Aotearoa-New Zealand, Australia, Austria, Canada, Georgia, Germany, India, Italy, Iran, Kenya, Kyrgyzstan, Mexico, Myanmar, Puerto Rico, Portugal, South Africa, Slovenia, Tajikistan, United States of America, and the United Kingdom. Updated information shows that Colombia and Moldova have recently began peer distribution naloxone.

[8] While the GSHR 2022 had registered Armenia as one of the countries that provide NSPs in prison, new updated information confirms that the country has suspended the NSP programme in prison. In contrast, Ukraine began implementing NSPs in prisons, while France resumed its prison NSPs programme.

[9] The number of countries providing OAT in prisons is unchanged at 59 in 2022. While OAT programmes are now operating in prisons in Kosovo, Macau, and Tanzania, this is balanced by new data indicating that prisons in Georgia, Hungary and Jordan only offer opioid agonists for detoxification.

[10] Since 2020, six more countries provide NSPs, including Burundi, Cote d'Ivoire, Democratic Republic of Congo, Guinea and Uganda. Three more countries provide OAT, namely Algeria, Mozambique and Uganda and four more countries implemented DCRs being Greece, Iceland, Mexico and United States.

[11] This includes a site in Mexico that had been operating without formal approval since 2018 but now has approval from local authorities.

[12] Algeria, Mozambique, and Uganda.

and use stimulants, finding that 19 countries[13] distribute safer smoking kits while 2 countries have nascent stimulant pharmacotherapy programmes.[14]

Despite evidence affirming that harm reduction is cost-effective and safe lives,[15] and regardless of UN agencies recommending its implementation, the availability of services, coverage, quality, and accessibility of services remains dire, with just 2% of the 15 million people who inject drugs globally living in a country with high coverage of both OAT and NSP.[16] The latest systemic review reported that 25% of people who inject drugs globally had experienced recent homelessness or unstable housing, close to 60% have a history of incarceration, and 14,9% had recently engaged in sex work.[17] Additionally, direct and structural racism leads to Black, Brown and Indigenous people having less access to harm reduction services. This is mainly due to Black, Brown and indigenous communities being targeted by drug law enforcement agencies and disproportionately detained or imprisoned.[18]

Globally, people who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services.[19] Human rights violations continue to be committed worldwide in the name of drug control. These include the denial of access to harm reduction services, including through the criminalisation of drug paraphernalia, the prohibition of OAT (for example, in Russia), and discrimination against people who use drugs in the provision of HIV and viral hepatitis care. Such punitive approaches hinder access to and drive people away from essential services, leading to unsafe practices which could increase their risk of transmissible diseases such as HIV and hepatitis. Furthermore, certain populations experience these barriers particularly acutely, most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people, who lack tailored services to meet their needs.

Question 2: Legal frameworks, policies and practices and their impact on access to harm reduction services.

Globally, people continue to face criminalisation that prevents access to harm reduction services. According to HRI's Global Overview, as of 2022, the death penalty for drug offences is retained in 35 countries, with more than 285 people executed and over 3000 people on death row, drug control remaining a key tool of social control by States.[20] Iran, a country that provides peer distribution and take-in-home naloxone, has the highest rates of executions for drug offences worldwide, recording at

[13] Austria, Belgium, Brazil, Canada, Czechia, Estonia, France, Germany, Italy, Indonesia, Moldova, the Netherlands, Portugal, Slovakia, Slovenia, Spain, Switzerland, the United Kingdom and the United States.
[14] Canada and Czechia.
[15] Harm Reduction International and HRAsia (2021) Divest. Redirect. Invest. The case for redirecting funds from ineffective drug law enforcement to harm reduction – spotlight on six countries in Asia, DOI 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/.
[16] Of these 15 million people, it is estimated that 2.8 million are women; 0.4% of people who inject drugs identify as transgender.
[17] Degenhardt. L, Webb. P, Colledge-Frisby. S, Ireland. J, Wheeler. A, Ottaviano. S, Willing. A, Kairouz. A, Cunningham. E.B, Hajarizadeh. B, Leung. J, Tran. L, Price. O, Peacock. P, Vickerman. P, Farrell. M, J Dore. G, Hickman. M and Grebely. J. (2023). Epidemiology of injecting drug use, prevalence of injecting related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *Lancet Global Health. 11:659. Doi https://doi.org/10.1016/ S2214-109X(23)00057-8*
[18] For more details see Joint submission to the Committee on the Elimination of Racial Discrimination. Doi https://hri.global/publications/joint-submission-to-the-un-committee-on-the-elimination-of-racial-discrimination/.
[19] Harm Reduction International (2022), 50th Session of the Human Rights Council: Drug Policy Highlights. DOI https://hri.global/publications/50th-session-of-the-human-rights-council-drug-policy-highlights/.
[20]Girelli, Jofré and Larasati. (2022) The Death Penalty for drug offences: Global Overview. *Harm Reduction International.* Doi https://hri.global/flagship-research/death-penalty/.

least 252 executions in 2022.[21] Indonesia, which explicitly supports harm reduction in national policy and provides NSPs and OAT (including in prison), still retains the death penalty for drug offences, with at least 122 people sentenced to death and 206 people on death row for drug offences in 2022.[22] Similarly, Vietnam also recognises harm reduction in its national policies and provides NSPs and OAT; however, 84 people were sentenced to death for drug offences in 2022.[23]

Strict rules with high thresholds and medicalised approaches to harm reduction may further stigma and discrimination, leading to the limitation in access to harm reduction services. In Eurasia, for example, to enrol in a programme, they require people to have a psychiatrist or other supporting documentation and a government-issued identity document, which in some cases, such as in North Macedonia, involves registering a residential address. More specifically, these enrolment requirements create a barrier to certain populations such as homeless people and Roma people who may not have ID or residential address. Similarly, in Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, and Ukraine, to enrol on OAT or other drug dependence treatment, people need to register in a drug user register, which can limit access to jobs and studies and may have repercussions in children's custody. In Belarus, for example, children are deemed to be in a 'socially dangerous situation' if they are parented by a woman who either uses drugs or is on OAT, in which case a mark is put in the parent's passport and medical records, increasing stigma, discrimination and further perpetuates sexist drug policy. Additionally, social services can take the child away from the family and parents must pay monthly fees to the state.

Racial discrimination alongside the criminal system and structural inequalities have hindered access to essential health and harm reduction services for Black, Brown, and Indigenous people who use drugs,[24] limiting access to life-saving harm reduction services, including opioid antagonists such as naloxone that can reverse overdoses. Punitive responses to drugs have disproportionately impacted people of colour and ethnic minorities, almost in all phases of the enforcement of drug laws and policies, from stops and searches to arrests, prosecutions, or incarceration, evidence showing that contact with the criminal justice system is a critical social determinant of physical and mental health, such as access to education and employment opportunities, as well as eligibility for social support.[25] In some cases, having a criminal conviction for drug offences impacts voting and parental rights. Experiences of imprisonment have also been linked to an increased likelihood of drug use and drug

[21] Girelli, Jofré and Larasati. (2022) The Death Penalty for Drug Offences: Global Overview. *Harm Reduction International.* p.28. Doi https://hri.global/flagship-research/death-penalty/.
[22] Girelli, Jofré and Larasati. (2022) The Death Penalty for drug offences: Global Overview. *Harm Reduction International.* p.28. Doi https://hri.global/flagship-research/death-penalty/.
[23] Girelli, Jofré and Larasati. (2022) The Death Penalty for drug offences: Global Overview. *Harm Reduction International.* p.28. Doi https://hri.global/flagship-research/death-penalty/.
[24] Joint submission to the United Nations Committee on the Elimination of Racial Discrimination. Comments to draft General Recommendation N.37 on racial discrimination in the enjoyment of the rights to health. 2023. Doi https://hri.global/publications/joint-submission-to-the-un-committee-on-the-elimination-of-racial-discrimination/; Joint Submission to the United Nations Committee on the Elimination of Racial Discrimination. Doi https://www.ohchr.org/sites/default/files/documents/hrbodies/cerd/discussions/right-health/2022-08-05/submission-racial-discrimination-and-right-to-health-cso-hri-idpc-and-cdpe.pdf; Joint submission to OHCHR on "Promotion and protection of the human rights and fundamental freedoms of Africa and of people of African descent against excessive use of force and other human rights violations by law enforcement officers". 2020. Doi https://hri.global/publications/submission-to-ohchr-on-the-protection-of-the-human-rights-and-fundamental-freedoms-of-people-of-african-descent/.
[25] For example, research from the US indicates that an experience of incarceration is associated with an up to 23% decline in employment and a 40% decline in income, with detrimental social, economic and health consequences.

dependence. Punitive drug laws and policies are also major drivers of non-consensual medical treatment.[26]

Question 3: Criminalisation of harm reduction tools and commodities.

Despite data indicating that 29 countries and 49 jurisdictions have adopted some form of decriminalisation for drug use and possession for personal use,[27] 'war on drug' paradigms still prevail. Criminalisation not only includes the production, sale and use of illegal substances but also encompasses the penalisation of the use and possession of drug paraphernalia.[28] This approach reinforces stigmatisation and discrimination, and, in many cases, it translates into the denial or limitation of harm reduction services. That is the case in the United Kingdom, where it is a criminal offence to supply or offer an object for providing or preparing a controlled drug,[29] including crack pipes, grinders, spoons, bongs and tourniquets, among others.[30] Despite safer smoke kits being essential harm reduction equipment, both for engaging people who use stimulants with harm reduction services and reducing transmission risks for HIV, hepatitis C and tuberculosis, its distribution is illegal in the country. The only exemption is aluminium foil, which is the only harm reduction equipment that is distributed for smoking.[31]

Notwithstanding the advances in harm reduction in the United States and in disregards of White House's model law on NSPs that recommends ending the criminalisation of syringes as drug paraphernalia, policy developments have been met with a significant backlash from conservative figures, who are particularly critical of the possibility that federal funds would be used for the distribution of safer smoking equipment. Some states continue to prevent lawful needle and syringe programmes (NSPs) from operating, despite high levels of HIV infections and overdoses. Other states criminalise drug paraphernalia including syringes and safer smoking and snorting supplies.[32] In July 2021, Oklahoma explicitly provided for NSP in law for the first time, but drug paraphernalia laws that criminalise syringe possession remain in place. In California, the governor vetoed a bill permitting overdose prevention sites that was passed in the legislature, falsely asserting that there was no real plan for the efforts.

Another example is the case of Russia, which has implemented a zero-tolerance to drugs and drug use. Russian national policy is explicitly against harm reduction service as they are considered to promote drug use and dependence. As a result, OAT is prohibited in detriment of people who use

[26] Within the criminal justice system, non-consensual drug treatment can take place in the form of compulsory drug detention, mandatory treatment by judicial order, or drug courts and other forms of coerced treatment in which people who use drugs are forced to choose between incarceration and treatment.
[27] Talking Drugs. https://www.talkingdrugs.org/decriminalisation/
[28] Drug paraphernalia is commonly understood as any equipment, tool or object used to produce, conceal, and use drugs, including syringes and pipes.
[29] The United Kingdom, Misuse of Drugs Act 1971, Doi http://www.legislation.gov.uk/ukpga/1971/38.
[30] It is not an offence to supply hypodermic syringes. Swabs, citric acid, filters, ascorbic acid and water ampoules of up to 5ml are also exempted as long as they are provided by a doctor, pharmacist or someone working legally within drug treatment services.
[31] Despite the United Kingdom's current paraphernalia laws, a pilot safe inhalation pipe provision programme has started in the country in four areas, with the local police force supporting the intervention, and safer smoking kit distribution will be available in the study's sites for six months in 2023.
[32] US states that criminalise all paraphernalia: Alabama, Arizona, Arkansas, Georgia, Idaho, Iowa, Kansas, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, Pennsylvania, South Dakota, Texas, and Wyoming. NSPs clients are exempted in Colorado, Delaware, Florida, Hawaii, Illinois, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Tennessee, Utah, Vermont, Virginia, and Washington.

drugs in the provision of HIV and viral hepatitis care. As a part of the implementation of the new drug policy strategy-2030, the distribution of "drug propaganda" (including online) is illegal in the country. The very concept of "drug propaganda" is very vague and can be used to prosecute not only organisations providing harm reduction services, but also independent media, as well as writers and musicians, making it hard to inform on safe drug use.[33] Additionally, according to HIV Justice Worldwide, Eastern Europe and Central Asia has the second highest number of laws criminalising HIV exposure, non-disclosure and transmission, with Belarus, Russia and Uzbekistan having particularly high numbers of criminal cases related to these laws. Russia has also continued to block harm reduction civil society organisations from gaining Special Consultative Status with the Economic and Social Council of the United Nations.

Question 4: Harm reduction as an enabler to advance human rights.

The implementation of harm reduction strategies and services can lead to furthering other human rights by advancing social justice, gender equality, poverty, among others. Harm reduction is grounded on principles of social justice, equity and non-discrimination, and dignity while acknowledging that all systems of oppression are interlinked. It also recognises that ending the 'war on drugs' involves addressing racial and patriarchal structures of power, including in the criminal justice system. Bellow, there are some cases to illustrate how harm reduction can be used as a tool to advance other human rights:

Integrated Harm Reduction Services[34]

Integrated Harm Reduction Services[35] are good examples of success in providing holistic care, allowing people to advance other human rights towards gender equality and social justice, moving beyond narrow frames of preventing and treating infections and overdoses through biomedical and behavioural interventions. With a multidisciplinary and person-centred approach, they can address the complex needs of their clients simultaneously and establish a closer relationship with them, empowering people to improve their health and reclaim their rights while increasing clients' engagement with primary care and social services. The involvement of the community is also crucial in the success of these services. Peers are uniquely able to win the trust of clients and have the knowledge and expertise to understand their experiences, favouring better outcomes. Evidence shows that integrated HIV and sexual and reproductive health services improve client satisfaction, reduce stigma and are better at reaching some more marginalised populations, such as sex workers, LGTBQ+ and women.

There are numerous organisations providing integrated harm reduction services for targeted specific groups. The Canberra Alliance for Harm Minimisation and Advocacy in Australia provides harm reduction services specifically tailored to the needs and practices of indigenous communities. CRESCER in Lisbon, Portugal, provides harm reduction services tailored for people experiencing homelessness. SPARSHA Nepal focuses on providing harm reduction services for people living with

[33]Bezverkha, Anastasia. (2021) Russia: A new drug policy in action. *Talking drugs.* Doi https://www.talkingdrugs.org/rossiya-novaya-narkopolitika-v-deystvii/.

[34] Harm Reduction International. (2021). Integrated and person-centred harm reduction services. *Harm Reduction International. Doi* https://hri.global/publications/integrated-harm-reduction-services/.

[35] An integrated harm reduction service is a site or organisation that provides one or more harm reduction services alongside other health and social services in a way that makes it easy for clients to move between those services.

HIV and has opened a specific drop-in centre for women, serving almost 200 women. AIDS Community Care Montréal runs a programme called Kontak, which is a harm reduction programme by and for gay, bisexual and queer men who have sex with men, with a special focus on people who use drugs during sex and sex parties (often known as chemsex or party'n'play).

Harm reduction and COVID-19

Harm reduction can also improve emergency health responses such as pandemics, including vaccinations rollouts. COVID-19 prevention and mitigation measures, including vaccination, are more likely to be accepted among people who use drugs when delivered and supported by harm reduction services. Evidence and best practices indicate that a human rights approach to vaccination should integrate harm reduction services, particularly community-led initiatives, in design and implementation, as they may help reach people who use drugs that would not otherwise access health services due to discrimination and criminalisation. Harm reduction services have proven to be central "in key interventions to reach public health goals such as reducing mortality and morbidity, including the elimination of HIV and hepatitis because they can reach people who use drugs where they are and deliver tailored services".[36] Similarly, including harm reduction services in vaccination planning and delivery could help increase vaccine coverage, as they are recognised and legitimised by their clients, which may promote adherence to medical treatments and vaccination programs. This is particularly important considering high rates of vaccine hesitancy among people who use drugs in certain countries.[37]

Due to the people-centred approach and the focus on community-led initiatives, harm reduction services could assist and provide some basic health services to people with HIV and people who use drugs when the public health system is overwhelmed or under high pressure. Despite harm reduction services being affected or disrupted during the pandemic, they proved resilient; organisations and community-led networks adapted quickly to maintain service coverage, adopted COVID-19 prevention measures, adjusted services delivery, and introduced innovative integrated methods to provide support, information, and access to harm reduction services.[38]

Question 5: Harm reduction, poverty, and human rights[39]

Drug use occurs across all demographics; however, those with economically and socially excluded background are disproportionately impacted by the harms of punitive drug policies, limiting access to essential health care and social services, among others. Poorer socio-economic groups are over-represented in the criminal justice system, being a root cause of women's imprisonment, with many being convicted of minor petty crimes driven by economic necessity. In the US, it has been found that women in State prisons are more likely than men to be imprisoned for a drug or property offence.[40]

[36] Harm Reduction International and UNODC (2022) "Tailoring Vaccination Campaigns and COVID-19 Services for People Who Use Drugs Technical Guidance". Doi https://hri.global/wp-content/uploads/2022/10/UNODC_HRI_Technical_Guidance_June_2022_FINAL.pdf p-7

[37] Harm Reduction International and UNODC (2022) "Tailoring Vaccination Campaigns and COVID-19 Services for People Who Use Drugs Technical Guidance". Doi https://hri.global/wp-content/uploads/2022/10/UNODC_HRI_Technical_Guidance_June_2022_FINAL.pdf p-14

[38] Harm Reduction International and UNODC (2022) "Tailoring Vaccination Campaigns and COVID-19 Services for People Who Use Drugs Technical Guidance". Doi https://hri.global/wp-content/uploads/2022/10/UNODC_HRI_Technical_Guidance_June_2022_FINAL.pdf p-6

[39] Unless stated otherwise, this section refers to the joint Submission to the United Nations Special Rapporteur on Extreme Poverty and Human Rights. 2019. Doi https://hri.global/publications/joint-submission-to-the-united-nations-special-rapporteur-on-extreme-poverty-and-human-rights-ahead-of-malaysia-visit/.

[40] Penal Reform International. (2023) Global Prison Trends. Doi https://cdn.penalreform.org/wp-content/uploads/2023/06/GPT-2023.pdf p.11

In Malaysia, a study found that 31% of women who use drugs were either homeless or unstable housed, and a staggering 91.3% had been jailed, and almost half had been placed in compulsory drug treatment detention centres. Evidence also shows that street-based in Malaysia are more likely to be searched and arrested.[41] Although legal aid being widely recognised in most countries, in practice, many poor and vulnerable accused persons are unable to exercise their right to effective legal representation, being more likely to end up in pre-trial detention or be convicted.[42] In Mexico, a study with women held in a prison in Ecatepec found that around 10% were charged for minor offences, and their detention was not because they posed a risk to society but because they were unable to cover fines, bail, or reparation costs.[43] This situation is even worse if we consider that the death penalty for drug offences disproportionately impacts poor and marginalised population who usually do not have legal representation or face various fair trial violations during their criminal case.[44] This situation gives a strong reasoning in making sure that harm reduction approach includes access to justice, especially to legal aid.

Evidence shows that people who live in poverty are more likely to die from overdose while having less access to harm reduction services[45]. People who use drugs experiencing homelessness are also more likely to have complex medical needs that can go unaddressed due to, and as a result of, their criminalisation, stigmatisation, and homelessness, living with multiple morbidities, such as mental health issues and long-term physical health conditions, and experiencing greater risk to their personal safety, including sexual violence. While not everyone who uses drugs is or becomes homeless, and not every homeless person uses drugs, drug use among people experiencing homelessness is common.[46] Inadequate housing has particularly adverse impacts for people who use drugs, including driving increased risk of drug-related harms, with higher prevalence of HIV, hepatitis C, tuberculosis, and drug-related deaths. For example, in 2017 drug poisoning, including overdose, made up 32% of the total number of deaths of homeless people in England and Wales. An analysis of 872 illicit drug overdose 7 deaths in British Columbia, Canada, between 2016 and 2017 revealed that 9% of individuals were experiencing homelessness at the time of their death.

[41] Joint Submission to the United Nations Special Rapporteur on Extreme Poverty and Human Rights. (2019) Doi https://hri.global/publications/joint-submission-to-the-united-nations-special-rapporteur-on-extreme-poverty-and-human-rights-ahead-of-malaysia-visit/.

[42] Penal Reform International. (2023) Global Prison Trends. Doi https://cdn.penalreform.org/wp-content/uploads/2023/06/GPT-2023.pdf p.14

[43] Penal Reform International. (2023) Global Prison Trends. Doi https://cdn.penalreform.org/wp-content/uploads/2023/06/GPT-2023.pdf p.11

[44] Girelli, Jofre, Larasati. (2022) Death Penalty for drug offences. Global Overview. Doi https://hri.global/flagship-research/death-penalty/the-death-penalty-for-drug-offences-global-overview-2022/.

[45] Altekruse SF, Cosgrove CM, Altekruse WC, Jenkins RA, Blanco C. (2020) Socioeconomic risk factors for fatal opioid overdoses in the United States: Findings from the Mortality Disparities in American Communities Study (MDAC). PLoS One. 17;15(1):e0227966. Doi: 10.1371/journal.pone.0227966. PMID: 31951640; PMCID: PMC6968850

[46] For example, in a single night overview of rough sleeping statistics for autumn 2018, it was reported that out of 4,677 'sleeping rough' in the UK, nearly 20% used drugs. 2 Point-in-time (PIT) counts of the homeless populations in North America have also published comparable statistics. The Seatle/King County PIT count has documented drug use within their homelessness population for several years; 36% in 2017, 35% in 2018 and 32% in 2019. Vancouver reported in 2019 that out of 2223 individuals 56% used drugs.

Question 6: Alternative measures to institutionalization or detention

Diversion scheme

Diversion could be an alternative measure to institutionalisation or detention for people who use drugs, usually applied to the possession of illegal drugs for personal use, or sometimes to minor supply or cultivation offenses.[47] Instead of receiving a criminal conviction, diversion allows people who use drugs to be diverted from the justice system towards treatment or education programs. Several countries have adopted diversion mechanisms including Australia and the UK. In Australia, diversion is provided through police, courts and specialist courts.[48] For instance, Western Australia implements Other Drug Intervention Requirement (ODIR) Scheme, a police diversion initiative, where eligible individuals would be required to complete three individually-focused, 60-minute sessions with a trained drug counsellor.[49] The UK applies a similar police-led programme, where instead of resorting to arresting or prosecuting, police offer to divert people to an assessment and/or specific support such as drug education, harm reduction or treatment.[50]

However, it is also important to mention that some diversion schemes, especially when they are formalized through drug courts, still put treatment in the hands of the criminal justice system that demands punishment of individuals. Therefore, it is necessary to implement non-coercive public health-based diversion initiatives.

Other alternatives

Portugal has the Commission for the Dissuasion from Drug Abuse (CDTs). When individuals use, purchase or possess a defined amount of illegal substances, the police will issue a report and schedule a meeting with CDTs. The Commission's purpose is to inform people, dissuade them from using drugs, and motivate them to seek treatment.[51] In the US, Kansas implements Senate Bill 123 (SB 123), which replaces incarceration with a mandatory community-based drug abuse treatment and community supervision for non-violent offenders convicted of a first- or second-offense drug possession. Eligible individuals may receive a community corrections sentence of up to 18 months with treatment varying from detoxification, drug education, outpatient and in-patient treatment, and relapse prevention.[52] In January 2015, Vientiane's Sisattanak Community Hospital in Laos introduced the nation's inaugural voluntary community-based treatment program. This initiative offers outpatient health and psychosocial support to individuals struggling with drug dependency on an outpatient basis with the goal of reducing the need and demand for centre-based and custodial options.[53]

[47] Transform Drug Policy Foundation. Doi: https://transformdrugs.org/drug-policy/uk-drug-policy/diversion-schemes#:~:text=Police%20offer%20to%20divert%20people,person%20complies%20with%20any%20conditions
[48] National Drug and Alcohol Research Center, NSW Australia. (2008) Doi https://ndarc.med.unsw.edu.au/resource/16-summary-diversion-programs-drug-and-drug-related-offenders-australia
[49] Government of Western Australia. Doi https://www.mhc.wa.gov.au/getting-help/diversion-support-programs/other-drug-intervention-requirement-odir/#:~:text=The%20Other%20Drug%20Intervention%20Requirement,within%20a%2042%20day%20period
[50] Transform Drug Policy Foundation. Doi: https://transformdrugs.org/drug-policy/uk-drug-policy/diversion-schemes#:~:text=Police%20offer%20to%20divert%20people,person%20complies%20with%20any%20conditions
[51] Silvestri, Arianna. Gateways from Crime to Health: The Portuguese Drug Commission. *Prison Reform Trust. Doi* https://www.sicad.pt/BK/Dissuasao/Documents/AS%20report%20GATEWAYS%20FROM%20CRIME%20TO%20HEALTH.pdf.
[52] Kansas Sentencing Commission. Doi https://sentencing.ks.gov/sb-123.
[53] UNODC. (2022) Compulsory Drug Treatment and Rehabilitation in East and Southeast Asia. Doi https://www.unodc.org/roseap/uploads/documents/Publications/2022/Booklet_3_12th_Jan_2022.pdf

While alternatives to institutionalisation or detention may not inherently be cruel, inhuman, or degrading, their misuse can still infringe upon human rights standards and norms, and in some context, it could lead to compulsory treatment, which is not in line with harm reduction principles. Moreover, it is crucial to recognize that regardless of the intent behind the alternatives, the individuals receiving it might still experience it as punitive.

Question 7: International donor funding on harm reduction, potential challenges from reliance on foreign assistance, and examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population.

Despite international donors' funding playing a pivotal role in the initiation and expansion of harm reduction programmes at a national level, it is still insufficient. Many low- and middle-income countries (LMICs) depend on international funding to secure the provision of harm reduction services. HRI's Failure to Fund report shows that in 2019, international donor funding constituted a substantial 52% of the total funding allocated to harm reduction efforts in LMICs, underlining its ongoing significance. Donor funding was identified in 50 out of 135 LMICs, with the largest share found in Asia, Eastern Europe and Central Asia (EECA), and sub-Saharan Africa. Relying heavily on foreign aid can be challenging since support may abruptly stop or decrease if donors' priorities change, resulting in a lack of sustainability. Additionally, despite the reliance in international funding, HRI's monitoring of the funding landscape shows a dearth of funding for life-saving services. In LMICs, funding for harm reduction is only 5% of the level needed to meet the estimated service needs for people who inject drugs by 2025. The gap between the required funding and the available funding has only grown wider in recent years.

Another issue is maintaining funding for advocating for long-term changes in national laws and policies. HRI's report on "The impact of a multi-country harm reduction advocacy grant in South-East Asia" shows that changing policies and laws usually takes consistent advocacy over a longer time than one grant covers. Therefore, to prevent the progress made through multi-country grants from disappearing when the grant ends, there needs to be ongoing support from international donor or other funding sources throughout the grant period. Of particular concern is the shrinking investment in advocacy for harm reduction, particularly community-led advocacy. Opportunities for funding harm reduction advocacy via multicountry grants from the Global Fund have significantly reduced, despite their positive impact. Without advocacy for national investment in harm reduction, services in LMICs will continue to be reliant on a shrinking pool of international funding. 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.

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 on new HIV infections and make the global goal to end AIDS among people who use drugs by 2030 achievable.[54] HRI's research in 2016 found it would be possible to fully fund the harm reduction response by redirecting just 7.5% of the funds spent on drug law enforcement towards harm reduction. Globally, USD 100 billion is spent on drug law enforcement, and just USD 131 million is

[54] Harm Reduction International. (2022) Submission to the Office of the High Commissioner on Human Rights (OHCHR) on Human Rights in the context of HIC/AIDS, pursuant to HRC 47/74 Doi. https://hri.global/wp-content/uploads/2022/10/HRI_-_Human_rights_HIV_AIDS_47_14-1.pdf.

spent on harm reduction in LMICs. HRI's recent report on "Aid for the war on drugs" shows that governments continue to underfund health programming for people who use drugs while investing enormous resources into punitive measures. Sustainable domestic funding, alongside international assistance, is crucial to create self-sustaining systems within each country.

Question 8: Harm reduction innovations in time of crisis

The COVID-19 pandemic caused death and suffering and significantly disrupted access to health services around the world, including harm reduction services. Some governments and service providers –especially peer-led services, demonstrated an incredible resolve and agility in this challenging context, adapting to unprecedented conditions with innovative responses and showing that it is possible to operate harm reduction services with fewer restrictions and greater client autonomy.

The most profound example of this was the change in OAT delivery across all regions. Out of the 84 countries worldwide where OAT was available in 2020, 47 countries[55] changed rules to allow for longer take-home periods. For example, in the UK most people were moved onto 7 to 14 days prescriptions instead of a daily or supervised pick-up OAT medication. Civil society reports that most of the clients receiving take-home OAT found this was an improvement in the service experience, while feeling more trusted and in control of their treatments. Similarly, in the US and Canada, take-home and mail-order OAT and initiating buprenorphine over telephone appointments were introduced in Canada and the US during the pandemic. Additionally, 23 countries made distribution more accessible with home delivery of OAT medication, offering dosing at community pharmacies, or distributing OAT in outreach settings. Online consultations replaced some face-to-face meetings in the Middle East and North Africa; in Eastern and Southern Africa, mobile van dispensing and buprenorphine. Service providers set up online shops for injecting equipment in the United Kingdom and New Zealand; and service providers introduced home delivery of harm reduction equipment in Eurasia and Western Europe.

Economic, political, humanitarian, and environmental crises have also put harm reduction at risk. Harm reduction movements - especially peer-led and community-led organisations- have shown to be resilient and have also adapted to guarantee continuity of care in times of war and social crisis. For example, when the Russian invasion started, Ukrainian harm reduction networks and networks of people who use drugs responded at astonishing speed to evacuate people who use drug from Donetsk and Luhansk areas while providing shelter, food, medication, and harm reduction supplies. Early in the war, VOLNA and the Ukrainian Network of Women who use drugs (VONA) successfully advocate for changing national OAT protocols allowing people to receive take-home doses and people no longer need to be registered in a city to receive OAT.

These innovations are important because they alter systems approaches which surveils and monitor people who use drugs. Daily supervised doses of methadone create a supportive environment and regular point of contact for some people. For others, the daily trip to a pharmacy or clinic impacts negatively upon privacy, family life and work. Daily observed doses convey a lack of trust between providers and clients - this is a pervasive issue across many health-based interactions for people who use drugs.

[55] Harm Reduction International. (2020) Global state of Harm Reduction. Doi https://hri.global/wp-content/uploads/2022/10/Global_State_HRI_2020_BOOK_FA_Web-1.pdf p-26.

Conclusion and recommendations:

Universal and equitable access to harm reduction is a human right obligation. It is recognised as an essential component of the right to the highest attainable standard of health for people who use drugs, from which States' obligations derive, specifically, ensuring availability, accessibility, acceptability, and quality of harm reduction services, removing barriers to access services such as stigmatisation and criminalisation of drug use and other practices, among others. Denial of harm reduction services, including in detention or closed settings, violate human rights obligations and in some cases may amount to torture and other cruel, inhumane, and degrading treatment[56].

In line with these international standards, and with the information provided through this submission we encourage the Special Rapporteur to recommend Member States to:

a) Decriminalise drug use and drug possession and promote evidence-based and health- and human-rights centred alternatives to incarceration;
b) Critically evaluate States' spending on drug control, divest from punitive drug control, and invest in evidence-based harm reduction programmes, ensuring the availability of funding for peer-led and community-led harm reduction initiatives, research, and innovation;
c) Recognise harm reduction as essential element to the right to health in national policies and strategies;
d) Guarantee equal access to harm reduction services and programmes in a no-discriminatory and non-stigmatizing way and consider the particular needs of the most vulnerable and marginalised groups, such as Black, Brown and indigenous population, LGTBQ+ people, sex workers, women among others;
e) Eliminate all form of forced drug dependency treatments;
f) Eliminate all legal and practical barrier to accessing harm reduction services, including those that affect marginalise populations including Black, Brown and ethnic minorities and indigenous populations, migrants, women, homeless and people living in poverty, and;
g) Abolish the death penalty for drug offences; and further address all causes of racial and gender discrimination, including in criminal justice system.

[56] Human Rights Committee (2015), Concluding observations of the seventh periodic report of the Russian Federation, UN Doc. CCPR/C/RUS/CO/7, para. 16; Méndez J. (2013), Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53, para. 55.); Harm Reduction International and HRAsia (2021) Divest. Redirect. Invest. The case for redirecting funds from ineffective drug law enforcement to harm reduction – spotlight on six countries in Asia, DOI 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/.