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THEMATIC SEGMENT BACKGROUND NOTE

Beyond 2025: Countering health inequities through sustaining the HIV response, human rights and harm reduction for people who use drugs

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Executive summary

People who inject drugs are central to the HIV response

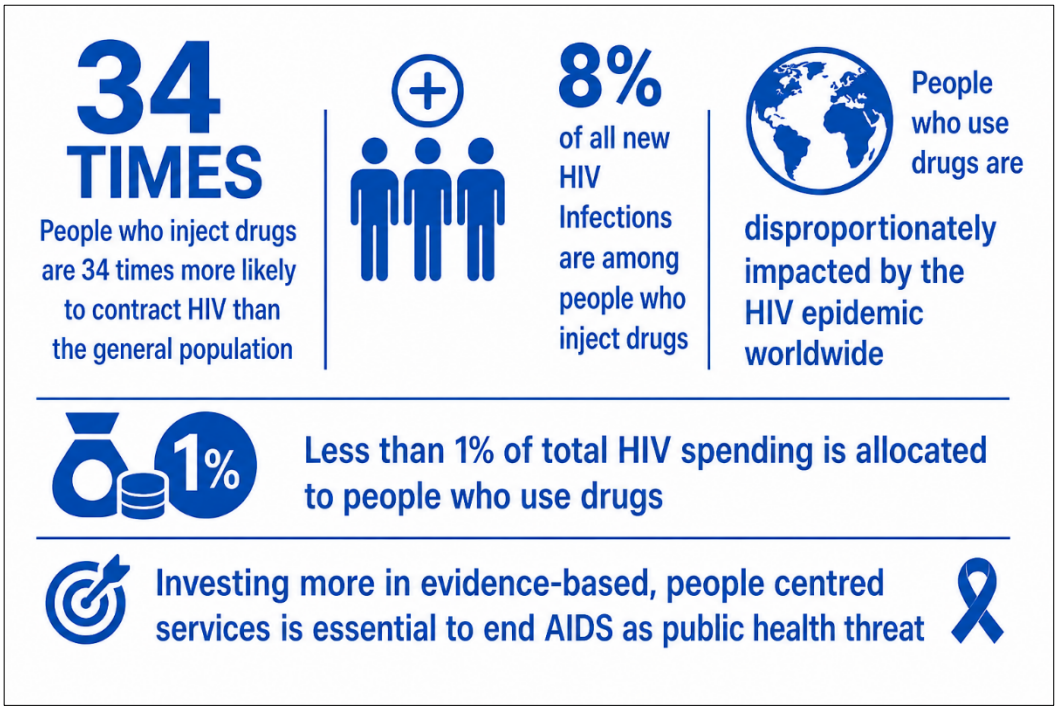
1. The global HIV response is at a fragile turning point. Decades of innovation and sustained efforts by communities, governments and scientists have reduced new HIV infections to their lowest level in nearly three decades. Yet this progress is uneven and increasingly precarious: in several regions and countries, new HIV infections are rising, and more than half of all new HIV acquisitions are among people from key populations and their sexual partners.

2. Persistent discrimination, stigma, punitive laws, gender inequalities and violence continue to undermine efforts to prevent HIV and to ensure healthy lives for people living with the virus. Despite bearing a disproportionate burden of the epidemic, people from key populations and their partners remain inadequately reached by HIV programmes.[1]

3. People who inject drugs are disproportionately impacted by the HIV epidemic worldwide, and unsafe injection of drugs contributes to rising trends. In 2024, the global median HIV prevalence among people who inject drugs reported to UNAIDS was ten times higher than for the rest of the adult (15–49 years) population,[2] people who inject drugs were estimated to be 34 times more likely to contract HIV than the general adult population, and 8% of all new HIV infections were among people who inject drugs.[3]

Figure 1. The HIV epidemic and people who inject drugs

Sources: UNAIDS special analyses 2025; UNAIDS financial estimates 2025; UNAIDS resource needs estimates to achieve 2030 Global targets, 2025.



Harm reduction has proven effective but availability falls far short of needs

4. The evidence is clear that harm reduction reduces the risk of HIV and hepatitis C infection, as well as overdose deaths and other harms among people who inject drugs. Harm reduction—including needle and syringe programmes, opioid agonist therapy, naloxone for overdose management, and policies and strategies to prevent public and individual harms—has proven highly effective.[4] Most of the healthy years of life lost due to consequences of drug use could have been prevented or reduced if harm reduction was made widely accessible.[5]

5. Harm reduction availability falls far short of needs. One systematic review estimated that, in 2022, only five countries globally achieved the goals of distributing more than 200 needles per person injecting drugs per year, and 50% coverage of opioid agonist maintenance therapy, where a combined total of only 2% of the global people who inject drugs population reside.[6] Access to PrEP for people who inject drugs is extremely low, and they face multiple barriers to access.[7] Harm reduction is even less available in prisons than in the general community, and prison and post-prison health services are rarely joined up. Harm reduction services are often male-centred, and fail to address the needs of women and young people.[8]

6. People who use drugs face structural and systemic inequalities, including multiple and intersecting forms of violence and criminalization, stigma and discrimination, and access barriers to health services. Harm reduction includes addressing structural drivers of HIV among people who inject drugs.

7. The compounded effects of conflict, climate change, and societal instability make harm reduction even less accessible, yet humanitarian responses often exclude people who inject drugs.[9]

Punitive approaches prevent progress but still predominate

8. Rising anti-gender, anti-rights, and anti-democracy movements tend to adopt moralistic and punitive approaches to drug use. Shrinking civic space impacts directly on service delivery and community organizing.[10] [11]

9. Yet there have also been advances in legal recognition of harm reduction approaches. Harm reduction is now explicitly recognized by UN human rights and drug policy frameworks.[12] UNAIDS, UNDP and INPUD have produced a new guidance note on the decriminalization of drug use, providing a powerful normative anchor for the response.[13] At national levels, 112 countries now make explicit supportive references to harm reduction in national policy documents, more than ever before.[14]

What works? Decriminalization, community leadership, human rights and public health approaches

10. Decriminalization works. In the early 2000s, Portugal decriminalized drug possession for personal use and treated drug dependence as an illness, providing extensive treatment and recovery support. From 2001 to 2017, the number of people using heroin fell from an estimated 100 000, to 25 000, fatal overdoses decreased by more than 85%, and new HIV diagnoses by more than 90%.[15]

11. Various decriminalization models, alternatives to criminal sanctions and other rights-based policies not only respect and protect human rights, but also improve health

outcomes. Mauritius shifted from a solely punitive approach to drug use to a public health one and introduced opioid agonist treatment in 2006 before extending it into prisons and expanding needle and syringe programmes. New HIV infections attributed to injecting drug use in Mauritius fell from 92% in 2005 to 28% in 2024. Estimated HIV prevalence among people who inject drugs declined from about 52% in 2011 to 21% in 2021.[16]

12. Community leadership works. Community-led networks and groups know how to reach people who use drugs, build trust and make services accessible to them. Most people who use drugs—especially, but not only those living in countries that criminalize drug use or possession—have little trust in formal health systems, and will not access harm reduction without community intermediaries. Community leadership includes community engagement in service delivery, monitoring and accountability mechanisms, and institutionalized participation in governance and decision-making at local and national levels.

People who inject drugs are allocated less than 1% of total HIV spending

13. People who inject drugs are central to the HIV response and to achieving the 2030 goal of ending AIDS as a public health threat. However, in 2025, donor funding for HIV programmes was reduced steeply.[17] Even before these reductions, harm reduction funding was inadequate, with less than 1% of total HIV spending allocated to people who inject drugs, according to UNAIDS estimates.[18] Donor funding for harm reduction halved in real value from 2007 to 2022,[19] while total harm reduction funding is only 5% of the estimated annual need in low- and middle-income countries in 2030.[20]

Shifting from punitive to public health approaches can save costs

14. Shifting funding from punitive approaches to harm reduction can be cost-effective and cost-saving.[21] In India, integrated needle and syringe programmes, opioid agonist therapy and wider harm reduction support was found to be cost-effective for HIV prevention, averting 996 HIV infections over three years.[22] A study from Seattle, United States of America, estimated that establishing a drug consumption room would save US$ 4.22 in associated healthcare costs for every dollar spent on operational costs.[23] In Indonesia, where the Ministry of Law and Human Rights in Indonesia in 2019 spent around 42% of its total annual budget on managing prisons,it has been estimated that, if personal possession of drugs were decriminalized, the burden on prisons and other closed settings would be reduced by 40%.[24]

Ways forward: domestically funded, integrated, community led harm reduction

15. Strengthening domestic investment in harm reduction and its integration into national health systems is more essential than ever to ensure the continuity of services and the protection of public health gains.[25] A community-led, person-centred approach to integration is needed to address the structural drivers of HIV risk among people who use drugs, improve access to services, and sustain health outcomes over time.

16. Albania and South Africa offer examples of domestically funded, integrated and community-led harm reduction. In South Africa, the Community-Oriented Substance Use Programme (COSUP) now delivers almost half of all harm reduction. Municipal funding is channelled through the Department of Health to the University of Pretoria, which sub-contracts community-led organizations to implement core service

components. COSUP illustrates how domestically financed, community-integrated harm reduction can safeguard service continuity, absorb donor shocks, and provide a scalable model for national replication.[26]

17. In Albania, opioid agonist therapy has been delivered for more than two decades by the nongovernmental sector with Global Fund support, operating largely outside the public health system. In late 2023, Albania undertook a major policy shift by integrating opioid agonist therapy into the public health system and transitioning to domestic financing, aligning harm reduction with national commitments to universal health coverage, sustainability of the HIV response, and equity for key populations.[27]

Recommendations

18. Recognize and fund harm reduction as an essential, evidence-based, rights-affirming and cost-effective component of the HIV response to accelerate progress towards achieving the global AIDS targets on prevention, ending stigma and discrimination, integration and community leadership. For that purpose, countries are urged to:

- **Account for the needs of people who use drugs in their diversity, including women and youth, LGBTI persons, sex workers, people in humanitarian settings and people in prisons**. Countries should ensure that harm reduction responses are tailored to the diverse realities of people who use drugs, recognizing that HIV risk and access to services are shaped by intersecting structural factors including gender inequality, age, sexual orientation and gender identity, incarceration, displacement and humanitarian crises. Heightened stigma, violence and legal barriers faced by women, young people, gender-diverse individuals, and people in prison and humanitarian settings who use drugs should be addressed through differentiated, gender- and youth-responsive approaches, including the integration of harm reduction into prison health services and humanitarian responses to ensure equitable access and improved health outcomes for all groups.
- **Integrate harm reduction into national budgets and health systems, in ways that strengthen and sustain community leadership, including through social contracting.** Sustained progress towards the global AIDS targets requires the integration of harm reduction into national health systems and domestic financing frameworks, moving towards institutionalized, people-centred models of care. Integration should be undertaken in ways that reinforce community-led service delivery, recognizing the critical role of organizations led by people who use drugs in ensuring trust and service accessibility. Mechanisms including social contracting should be developed and scaled-up to provide public finance for community-led organizations, while integrated service delivery can improve linkage across HIV, viral hepatitis and broader health and social services.
- **Remove criminal sanctions for drug use and possession for personal use to improve access to HIV services.** Countries are urged to remove criminal sanctions for drug use and possession for personal use and adopt public health and human rights–based approaches, recognizing that criminalization and stigma undermine access to HIV services, while decriminalization improves health outcomes and service uptake. Aligning national legal frameworks with the latest international guidance can reduce harm, decrease incarceration and create enabling environments for effective HIV responses, contributing directly to targets on eliminating stigma and discrimination and reducing punitive laws.
- **Ensure that organizations led by people who use drugs and wider civil society which are engaged in harm reduction advocacy, service delivery and accountability processes can freely register, operate and apply for domestic and international funding.** Shrinking civic space, legal barriers and funding

constraints undermine community-led service delivery, advocacy and accountability, despite strong evidence that such organizations are central to reaching underserved populations and monitoring the quality and equity of services. To sustain effective harm reduction programmes, maintain service continuity and advance gains in HIV responses, countries should support community leadership, including through legal protection, financing and capacity strengthening. Countries should ensure that organizations led by people who use drugs, including women and young people, and broader civil society can freely register, operate and access both domestic and international funding.

- **Collect and use disaggregated data, including community-generated data, to understand gaps in services and support decision-making on planning of HIV services for people who use drugs and targeted investment in harm reduction**. Countries should strengthen strategic information systems by collecting and using high-quality, disaggregated data on people who inject and use drugs, including by age, gender and other relevant characteristics, to better understand service gaps and guide targeted investments. Countries should also support collecting and using community-generated data, including through community-led monitoring, to better capture lived realities, identify barriers to access and strengthen accountability within the HIV response. Expanding the availability, quality and use of such data will enable more effective planning, resource allocation and tracking of progress towards global targets, while ensuring that responsiveness to the needs of those most affected by HIV.

Introduction

19. Decades of innovation and sustained efforts by communities, governments and scientists have reduced new HIV infections to their lowest level in nearly three decades. Yet this progress is uneven and increasingly precarious: in several regions and countries, new HIV infections are rising, and more than half of all new acquisitions are occurring among people from key populations and their sexual partners.[28]

20. Persistent discrimination, stigma, punitive laws, gender inequalities and violence continue to undermine efforts to prevent HIV infection and to ensure healthy lives for people living with the virus. Despite bearing a disproportionate burden of the epidemic, people from key populations and their partners remain inadequately reached by HIV programmes. People who inject drugs are disproportionately affected by the HIV epidemic, and unsafe injection of drugs is contributing to rising numbers of new infections in some places.[29]

21. People who inject drugs are central to the HIV response and to reaching the global AIDS targets. Globally in 2024, an estimated 85 000 new infections occurred among people who inject drugs, representing approximately 8% of all new infections in that year.[30] In 2024, the global median HIV prevalence among people who inject drugs reported to UNAIDS was 7% (54 reporting countries), ten times higher than for the rest of the adult (15–49 years) population.[31] The number of people who inject drugs did not decrease between 2013 to 2023[32] and there are growing HIV epidemics in this population in some countries.[33]

22. In 2022, an estimated 9% of people who inject drugs acquired new hepatitis C infections, up from 8% in 2020.[34] Earlier data, for 2019, indicated that almost half of the people who injected drugs globally were living with hepatitis C.[35]

23. Harm reduction is a key part of a public health approach and it has been proven highly effective in reducing and mitigating the harms of injecting drug use for individuals and communities.[36] UN human rights and drug policy frameworks now explicitly recognize harm reduction,[37] while some countries are implementing needle syringe programmes and opioid agonist treatment without using the label “harm reduction”.

> **What is harm reduction?**
>
> WHO defines harm reduction as a comprehensive package of evidence-based interventions, based on public health and human rights, including needle and syringe programmes, opioid agonist maintenance treatment, and naloxone for overdose management. Harm reduction also refers to policies and strategies that aim to prevent major public and individual health harms, including HIV, viral hepatitis and overdose, without necessarily stopping drug use.
>
> – Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2022, p49[38]

24. Structural and social inequalities—including criminalization, stigma, discrimination, poverty and social marginalization—drive HIV risk, heighten the likelihood of unsafe drug use, limit access to essential harm reduction services, and contribute to almost 600 000 drug-related deaths annually (2019 WHO estimates).[39]

25. Most of the healthy years of life lost due to consequences of drug use can be prevented or reduced if harm reduction is made widely accessible.[40] The effectiveness of harm reduction is demonstrated by the evidence: it does not increase drug use[41] and it is a core component of the HIV response and broader public health obligations.[42] It is also cost-effective.[43] In contrast, criminalization of drug use neither deters drug use nor reduces its harms.[44]

26. Despite continued high levels of public expenditure on the criminalization and incarceration of people who use drugs, harm reduction financing was cut sharply in 2025 after having declined significantly in real value in the previous years.[45] In 2023, an estimated US$ 151 million was allocated for harm reduction in low- and middle-income countries,[46] an amount manifold lower than the estimated annual need of US$ 1.5 billion in 2030.[47]

27. This background note provides an overview of the available current HIV epidemiological data related to people who inject drugs, progress against global HIV targets, gaps in the HIV response, as well as the availability and uptake of HIV services for people who inject drugs. It is the first such update since the PCB thematic segment on drugs in 2014.

28. This note recognizes that the inequalities experienced by people who use drugs are driven by structural and systemic factors, including multiple and intersecting forms of violence and criminalization, stigma and discrimination, and access barriers to health services. It therefore focuses on societal enablers and the role of human rights in an equitable and sustainable response for people who use drugs, particularly those living with and affected by HIV. It also takes a broader look at drug policy and harm reduction in the context of humanitarian crises and displacement due to climate change, conflict and war.

29. In terms of sustainability, the background note explores the need to prioritize sufficient funding for harm reduction services, non-punitive alternatives to criminal sanctions, and other societal enablers. It focuses on community leadership and on sustainable and equitable service delivery models that address the needs of youth and women who use drugs and charts a way forward for harm reduction in a changing world.

30. The note features examples from all regions of initiatives that are being implemented to reduce inequalities and create a sustainable HIV response for people who use drugs, especially those relating to human rights, harm reduction and the improvement of broader health outcomes.

31. Finally, recommendations are made for improving the sustainability and equity of the HIV response for people who use drugs in all their diversity; at national, regional and global levels; across different thematic areas, including strategic information and progress against AIDS targets, human rights and inequities, sustainability and the future of harm reduction in a changing world.

Epidemiology

32. A UNAIDS special analysis has estimated that, globally in 2024, about 8% of new HIV infections occurred among people who inject drugs.[48] In 2024, the median reported HIV prevalence among people who inject drugs was 7% (54 reporting countries), ten times higher than for the rest of the adult population. Eastern and southern Africa (11%) and

Asia and the Pacific (8%) were the regions with the highest prevalence of HIV among people who inject drugs.[49] The largest estimated numbers of people who inject drugs and were living with HIV were in eastern Europe (430 000 people) and East and South-East Asia (262 000).[50] The reported median HIV prevalence in 2024 in countries with gender-disaggregated data was 9% among men who inject drugs and 15% among women who inject drugs (20 reporting countries).[i] [51]

33. Drug use-related death significantly increased since 1990. The World Health Organization (WHO) estimated that over 580 000 deaths were attributable to drug use in 2019, with more than 250 000 attributable to hepatitis C infection and more than 50 000 due to HIV.[52] The UN Office on Drug and Crime's 2025 *World drug report* attributed over 67 000 deaths of people who use drugs to HIV in 2021.[53]

34. A lack of data on key population sizes in countries tends to render people who inject drugs invisible in certain policy spaces and makes it difficult to plan for adequate health service coverage.[54] Where such data do exist, they are rarely sufficiently disaggregated, for example by gender, age or other relevant characteristics, which poses a challenge for service planning and monitoring. Only 96 countries have ever reported data on population size estimates of people who inject drugs to the UNAIDS Global AIDS Monitoring process.

Global goals and progress towards meeting them

35. Sustainable Development Goal 3.3 includes ending AIDS as a public health threat by 2030. The AIDS Strategy 2026–2031 sets out targets which have to be reached to achieve that goal.[55] Its 16 top-line targets to end AIDS as a public health threat by 2030 and ensure sustainability of the HIV response after 2030 are outlined below.

[i] The number of reporting countries refers to the number of countries which reported data on the specific indicator to the UNAIDS Global Aids Monitoring process.

Figure 2. Global AIDS targets 2030

Source: The Global AIDS Strategy for 2026–2031: united towards ending AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2026.

36. In addition to the 16 top-line targets, there are a further 50 second-tier global targets for 2030 which countries should consider incorporating into their national HIV strategies and programmes, where progress towards the top-line targets is insufficient. Second-tier targets specific to people who use drugs are:

- 95% of people who inject drugs used safe injecting equipment during their last injection; and
- 50% use of opioid agonist maintenance treatment among people who inject opioids.

37. On the current trajectory, the AIDS targets will not be met by the stipulated deadline and progress is falling far short of the 95–95–95 targets for people who inject drugs. A 2023 systematic review found that globally, an estimated 49% of people who inject

drugs were tested for HIV antibodies in the previous year and 47% had ever been tested for hepatitis C virus (HCV) antibodies. The estimated uptake of HIV treatment (data from 18 countries) ranged from 2.6% to 82%, and the estimated uptake of people ever having HCV treatment (23 countries) ranged from 1.8% to 89% across countries.[56] Another 2023 global systematic review found that only one third of people who inject drugs living with HIV (33%) and about half of those receiving antiretroviral therapy (ART) (53%) had viral suppression.[57] Those proportions are lower than for the general population and for some other key population groups.

38. Between 2020 and 2024, the coverage of combination HIV prevention among people who inject drugs was low globally, with a reported median of 39% receiving at least two prevention services in the previous three months in 22 reporting countries.[58]

39. A median of 35% of people who inject drugs reported experiencing stigma and discrimination in the previous six months (16 reporting countries), and 17% of people who inject drugs reported avoiding accessing healthcare services due to stigma and discrimination in the past 12 months in 2024 (23 reporting countries).[59]

40. In 2024, a median of 23% of people who inject drugs reported experiencing violence in the past 12 months (18 reporting countries).[60] A 2019 systematic review found the prevalence of intimate partner violence experienced by women who had used opioids was 36–94% in their lifetime and 32–75% in the previous year.[61]

41. In 2025, 152 countries criminalized the possession of small amounts of drugs for personal use, with some still applying minimum mandatory sentences. Currently, 29 countries do not criminalize possession of small amounts of drugs, while civil society organizations report that up to 39 countries have adopted some form of decriminalization model.[62] [63] Some countries, such as Italy and Spain, have had decriminalization models in place since the 1980s or early 1990s.[64] [65] The number of countries recognizing harm reduction approaches in national policy is increasing.[66]

42. Data from 2020–2024 (38 countries) indicate that about 14% on needle and syringe distribution was done by key population-led organizations and 61% by other types of nongovernmental organizations. In the 21 countries reporting disaggregated data on the distribution of opioid agonist maintenance therapy, only 1% of patients reported that the service was provided by key population-led organizations and 4% said it was offered by other nongovernmental organizations.[67] Community-led services have been hardest hit by recent funding cuts, and their continuity is under threat.[68] Data relating to the 30–80–60 targets (regarding the involvement of community-led organizations in HIV service provision) are limited. A monitoring framework is being developed with the participation of representatives from global networks of people living with HIV and key populations.[69]

43. A systematic review estimated that, in 2022, only five countries globally achieved a distribution of more than an average of 200 needles per person injecting drugs per year,[ii] and 50% coverage of opioid agonist maintenance therapy. The countries were Australia, Austria, Norway, Netherlands and Canada, home to a combined total of only

[ii] The target reported on here calls for distributing of an average of at least 200 syringes per person injecting drugs per year. WHO now recommends the distribution of an average of at least 300 syringes per person injecting drugs per year by 2030, in line with levels needed for improved prevention of hepatitis C, as well as HIV. See: Needle and syringe programmes for People who inject drugs: operational guide. Geneva: World Health Organization; 2026 (https://www.who.int/publications/i/item/9789240116214).

2% of all people who inject drugs.[70] Since 2020, only two of 32 reporting countries reported distributing more than 200 needles per person who inject drugs per year (Bangladesh and Myanmar), and only two of 25 reporting countries reported achieving 50% coverage of opioid agonist maintenance therapy (Malaysia and Seychelles). No country reported achieving both targets.[71]

44. Thirteen of 35 reporting countries achieved the 90% target on coverage of safe injecting practices since 2020 and a median of 90% of men who inject drugs and 93% of women who inject drugs reported safe injecting practices at last injection (11 reporting countries).[72] Those figures may not be globally representative.

45. Countries also lag in full implementation of the WHO recommended package of interventions for key populations in relation to HIV, viral hepatitis and STIs,[73] which is also supported by UNODC and INPUD in their publication, *Recommended package of interventions for HIV, viral hepatitis and sexually transmitted infection prevention, diagnosis, treatment and care for people who inject drugs*.[74] The recommended package includes enabling interventions addressing structural drivers and health interventions related to drug use and HIV, including harm reduction, as well as other health issues such as viral hepatitis, mental health, reproductive health and tuberculosis. In several countries, harm reduction service provision has decreased in the past year due to funding cuts; they may now lag even further behind in providing sufficient access to that package of services.[75]

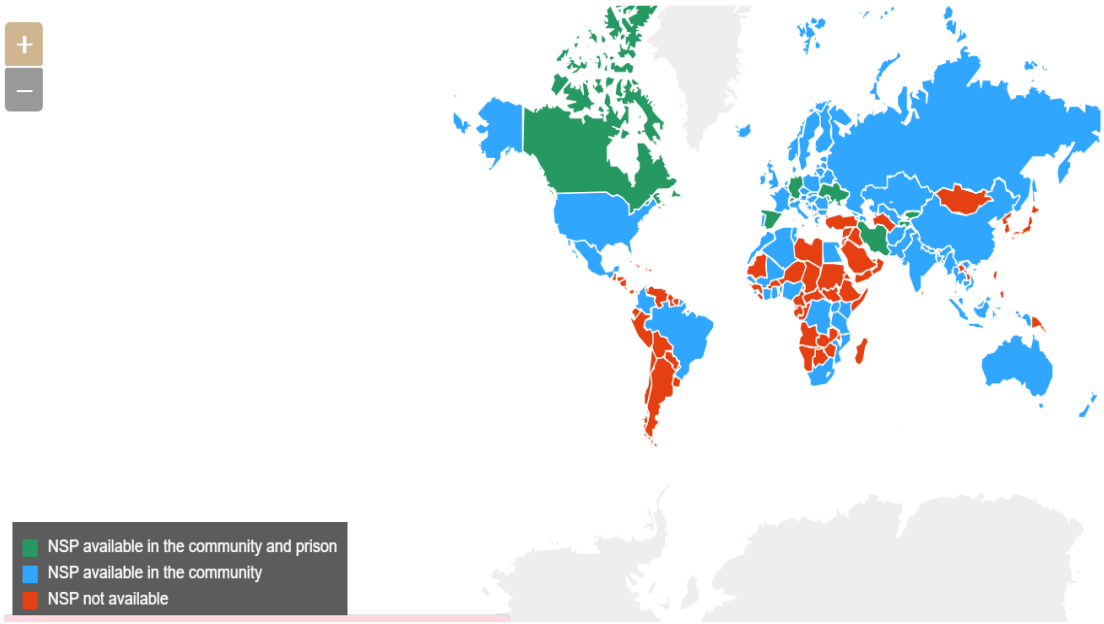
Inequalities preventing progress in the HIV response for people who use drugs

Availability of harm reduction interventions

46. Harm reduction interventions are severely lacking. Most countries are failing to reach targets, leaving people who use drugs at higher risk of harm and death. The HIV response among people who use drugs is not only inadequate, in some contexts it is deteriorating due to funding cuts and policy shifts.[76]

47. Drug use is significantly more prevalent in prison than in the general population, with about one third of people in prisons and closed settings reporting using drugs during their incarceration.[77] Unsafe drug use is common in prisons; combined with low access to prevention and lack of healthcare, it increases the risk of acquiring infectious diseases.[78] The risk of death from drug-related causes spikes during the two weeks after release from prison.[79] Yet harm reduction services are even less available in prisons than in the rest of society, and prison and post-prison health services are rarely joined up. Where services do exist, people face numerous access barriers, from restrictions on starting treatment while incarcerated to breaches of confidentiality and pervasive stigma. Harm reduction in prison is limited in scale and is available in very few countries outside Eurasia and western Europe. As of 2025, 93 countries were operating at least one needle and syringe programme, but only 11 countries had programmes in at least one prison.[80]

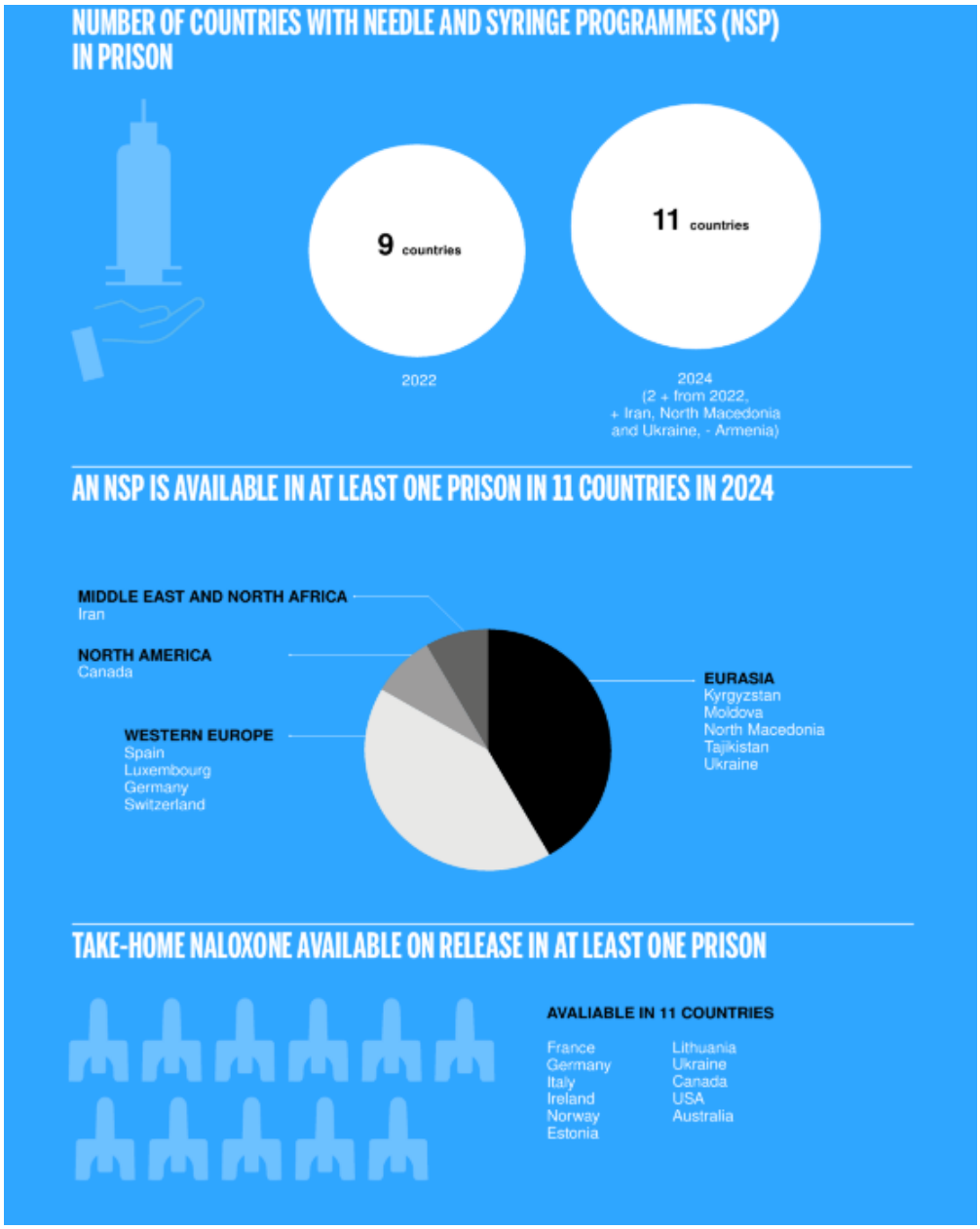
Figure 3. Availability of needle and syringe programmes in communities and prisons



Source: https://hri.global/publications/global-state-of-harm-reduction-2025-update-to-key-data/

48. Naloxone is reportedly available on release in at least one prison in 11 countries. Only one country (Canada) has implemented drug consumption room in prison. No overdose deaths have taken place in prisons where drug consumption rooms have become active.[81]

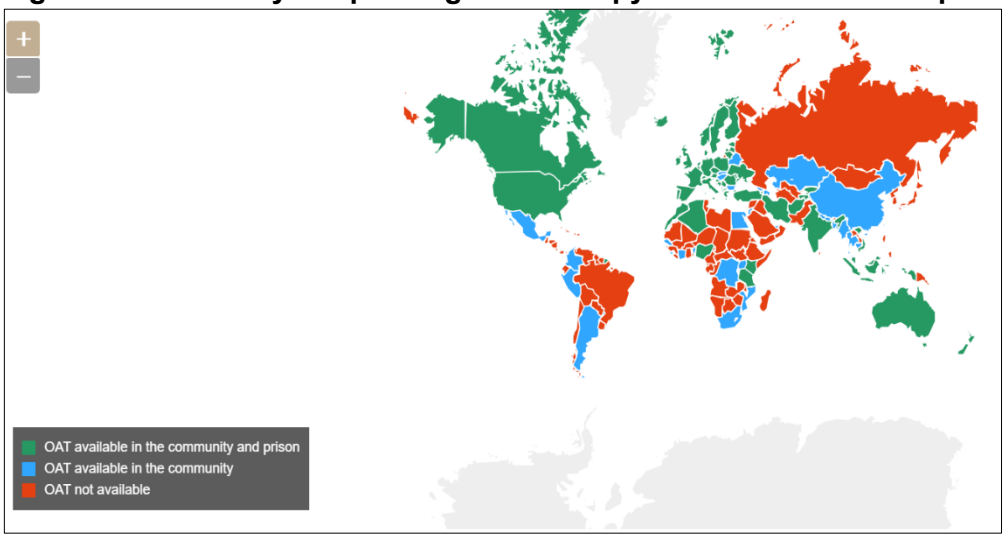
Figure 4. Availability of harm reduction services in prisons, 2024



Source: *The global state of harm reduction,* 9th Edition. London: Harm Reduction International; 2024.

49. Ninety-five countries had at least one opioid agonist therapy programme in 2025 and 60 countries had such a programme in at least one prison.[82] Long-acting formulations of opioid agonist therapy, such as depot buprenorphine opioid agonist therapy, are only available in a small number of high-income countries such as Canada, Australia, Czech Republic, Ireland and Spain.[83]

Figure 5. Availability of opioid agonist therapy in communities and prisons



Source: https://hri.global/publications/global-state-of-harm-reduction-2025-update-to-key-data/

Figure 6. Availability of opioid agonist therapy in prisons, 2024

Source: Harm Reduction International, 2024, *The Global State of Harm Reduction,* 9th Edition.

Inequalities in HIV prevention, testing and treatment for people who inject drugs

50. People who inject drugs are disproportionately impacted by the HIV epidemic. Globally, people who inject drugs are 34 times more at risk of contracting HIV than the general adult population, while an estimated 8% of all new HIV infections were among people who inject drugs, according to 2024 data.[84] Overall, between 2013 and 2023, neither

the estimated number of people who inject drugs and were living with HIV nor the global prevalence of HIV among people who inject drugs decreased.[85]

51. Access to pre-exposure prophylaxis (PrEP) for people who inject drugs is extremely limited, due to multiple barriers. A 2023 global mapping exercise found that 27 countries offered PrEP services to people who inject drugs; 15 of those countries were high-income ones. Many of those countries offered only limited services in specific locations,[86] despite the importance of PrEP for reducing HIV transmission.[87] A study in Bangkok showed oral PrEP to be efficacious among people who inject drugs, with those taking oral Tenofovir having 49% lower risk of contracting HIV than those receiving a placebo,[88] and 84% lower risk where adherence was consistent.[89] Several studies have demonstrated that people who inject drugs are willing to take PrEP.[90] [91] [92] However, recent funding cuts have further reduced their access to PrEP.[93]

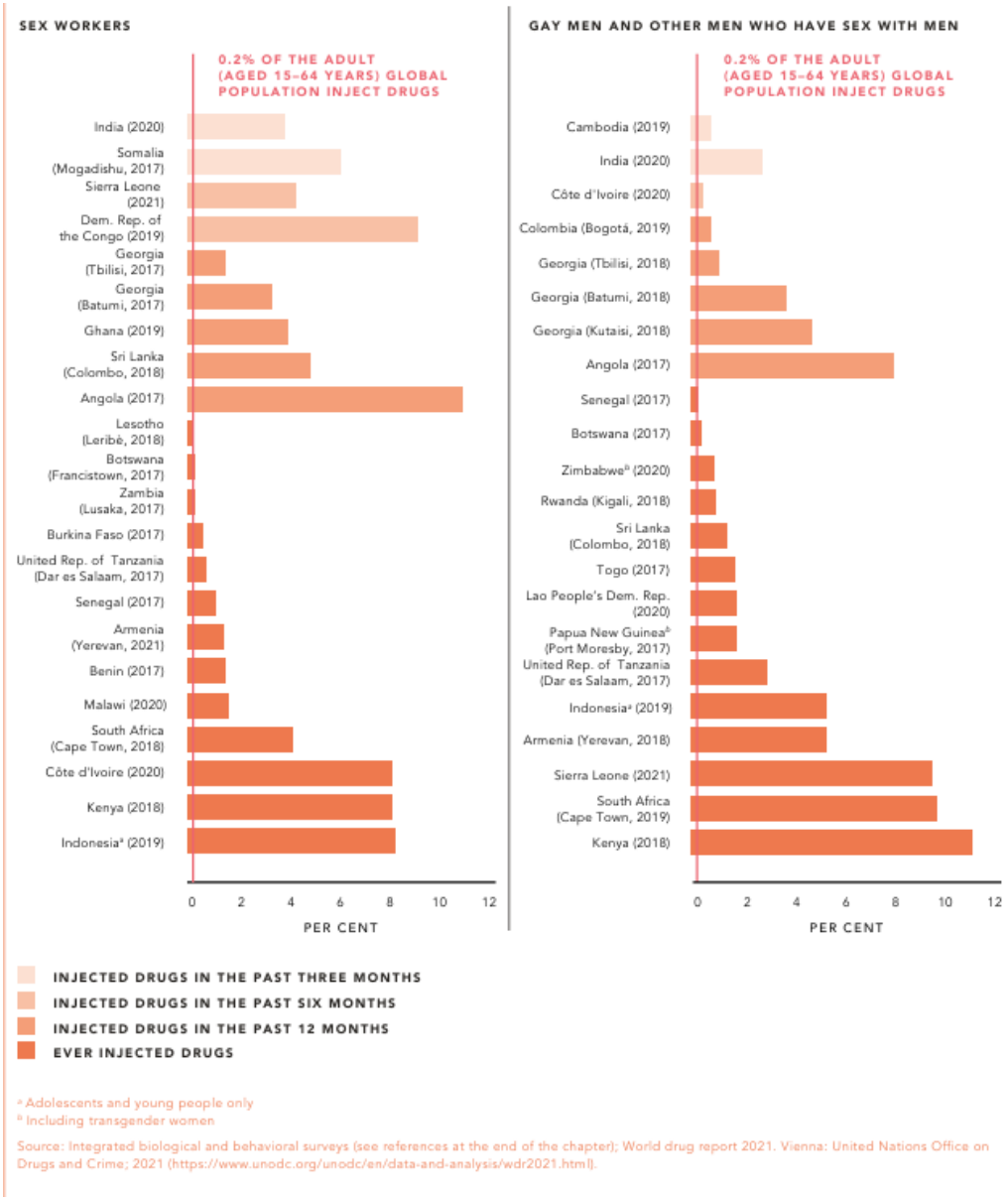
52. A 2020 global meta-analysis found co-infection of HIV and Hepatitis C (HCV) to be 72% among people who inject drugs;[94] in some settings the prevalence of co-infection has been as high as 90–95%.[95] Co-infection negatively affects HIV treatment outcomes, while HIV infection increases liver damage in patients with HCV. Access to viral hepatitis prevention, testing and treatment among people who inject drugs is very important. It is critical to manage both HIV and viral hepatitis, and to monitor and manage interactions between treatments. Funding cuts have impacted both HIV and viral hepatitis services.[96]

53. About one in four people who inject drugs is a woman (based on limited data from 23 countries), but women who inject drugs are 1.2 times more likely than men to be living with HIV (on the basis of limited data from 63 countries).[97] Among the 20 countries reporting gender-disaggregated data, median HIV prevalence among women who inject drugs was almost twice higher than among men who inject drugs. Coverage of opioid agonist maintenance therapy in the ten reporting countries with gender disaggregated data was 10% for men and 7% for women.[98] Women who use drugs have limited access to contraception and to antenatal and postnatal care, and have poor access to ART and prevention of vertical HIV transmission services.[99]

54. The prevalence of drug use among young people (ages 15-24) is similar to or higher than among adults,[100] but young people who inject drugs are 50% more likely to acquire HIV and hepatitis C. Young people who inject drugs face intersectional exclusion and layered stigma and discrimination.

55. The global median of HIV prevalence reported among people in prison in 2024 was double that of the general population. Where harm reduction is provided, it is often concentrated in urban facilities and men's prisons, with much more limited availability in rural settings and women's prisons.[101] Trans and gender diverse people are more likely to be held in solitary confinement, reducing their access to harm reduction. [102]

Figure 7. Prevalence and frequency of injecting drug use among sex workers and gay men and other men who have sex with men, selected countries, 2017–2021



Structural barriers that are preventing progress

56. The evidence shows that criminalization, punitive laws and practices prevent progress on health and HIV and do not deter drug use. Furthermore, some punishments undermine public health and contravene human rights obligations. Drug paraphernalia laws which criminalize the possession of harm reduction equipment such as needles and syringes undermine HIV prevention efforts.[103] Punitive policing practices can drive people away from health services, and contribute to deaths.[104]

> *There is a guy here who is overdosing … clearly overdosing. So, there is somebody who has a Narcan kit and the cops are going he's fine. And the guy is going, "I'm going to give him Narcan," right. The other cop is going, "he's fine." I said I have a Narcan kit. And the cop said he's fine. Quite clearly you're not going to go through the line of cops. Pretty soon he stopped convulsing and died.*

– Incident on a street in Vancouver, Canada, as recalled by an activist who uses drugs[105]

57. People who use drugs face intersectional exclusion. Intersectionality is not the simple addition of marginalization, but refers to the ways in which various social, legal and structural factors interact to shape people's lived realities, access to services, and health outcomes. Discrimination can be intense for people who use drugs and also engage in sex work, have prison experience, or face structural barriers such as racism, homophobia and transphobia.[106] The relative importance of these factors shifts depending on context. For example, while gender identity, sexual orientation, and race may increase marginalization in many settings, other determinants—such as citizenship status, access to welfare systems, or financial stability—can outweigh those factors and confer relative advantage.

58. For people who use drugs, experiences of HIV risk and access to care are shaped by complex and context-specific intersections of socio-demographic and structural factors, which in turn shape their exposure to poverty, trauma, social exclusion, criminalization and stress, and limit their access to education, health, and support networks. These conditions do not determine whether someone uses drugs, but they do influence the likelihood that drug use becomes problematic, as well as the extent to which individuals are able to engage in safer practices and access services. As a result, people experiencing multiple and overlapping forms of marginalization—such as transwomen of colour—are more likely to encounter factors that increase their risk of problematic drug use and HIV.

59. Contexts of drug use are diverse and shape the risks people could face and the responses they need. Those contexts include: chemsex/sexualized drug use;[iii] nightlife and social consumption settings; survival economies and informal work; displacement and humanitarian settings; pain management and medical use of controlled substances; culturally and imbedded practices; and ritualistic and traditional use, particularly among Indigenous communities. These contexts intersect in different ways with structural determinants.

60. Drug use patterns are shifting. Rising methamphetamine, cocaine and other stimulant use in Asia and other regions presents growing risks for HIV, viral hepatitis, and mental health harms, while treatment options remain limited.[107] Use of synthetic opioids are also on the rise. Drug use patterns vary widely between urban and rural settings and between populations. Digital platforms are used to communicate, buy drugs and share information and offer opportunities for innovative outreach work. Harm reduction must adapt to the diversity of drug use contexts and changing patterns of drug use.[108]

61. Rates of chemsex are relatively higher among transgender people and gay, bisexual and other men who have sex with men.[109] A 2025 meta-analysis found that up to 25% of gay, bisexual and other men who have sex with men engaged in sexualized drug use, which can include injecting and/or non-injecting drugs.[110] WHO's *Consolidated guidelines on HIV, viral hepatitis and STI prevention among key populations* now

[iii] Chemsex is defined as "when individuals engage in sexual activity, while taking primarily stimulant drugs, typically involving multiple participants and over a prolonged time." Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2022 (https://www.who.int/publications/i/item/9789240052390), p33.

includes a recommendation on chemsex.[iv] Chemsex interventions are recommended for men who have sex with men, transgender people, sex workers and people who inject drugs.[111]

62. With chemsex, sexual orientation, gender identity, drug use and HIV intersect, with people often facing interconnected stigma and discrimination across all dimensions. Interventions including both biomedical and social dimensions of harm reduction, peer-led interventions, trans-specific healthcare, comprehensive sexuality education, mental health support, and sexual and reproductive health services have been shown to be effective in reducing the risks of sexualized drug use.[112] [113] However, coverage remains inadequate.

63. In Fiji in 2023–2024, the number of people newly diagnosed with HIV tripled in one year, with unsafe injection of drugs one of the major drivers.[114] National statistics show that HIV disproportionately impacts young people, iTaukei (Indigenous Fijian) communities and males, while transgender women and sex workers are also overrepresented. Among people newly initiated on HIV treatment in 2024 for whom an HIV exposure category was recorded, 48% reported injecting drug use as their primary risk behaviour.[115]

64. In Fiji, methamphetamine is the most commonly injected drug, often injected daily or several times a day, sometimes in a context of sexualized use. Availability of needles and syringes is limited and they are widely shared. People using drugs report high-risk drug preparation and mixing practices, involving the use of blood as a solvent to dissolve methamphetamine. They also face wide-spread criminalization and stigma, including from healthcare providers, and lack trust in health and other services. Information about HIV and other blood-borne virus transmission and about available services is limited. Most people who use drugs in Fiji do not know that HIV can be treated and they are reluctant to be tested in a stigmatizing environment.[116]

65. Structural factors and vulnerabilities of young people—such as criminalization and age of consent laws, stigma and discrimination, and lack of youth-friendly services and youth participation in policy and programming—reduce young people's access to prevention, harm reduction and sexual and reproductive health services, and put them at higher risk of acquiring HIV, sexually transmitted infections and viral hepatitis.

66. Harm reduction interventions tend to be designed for adults,[117] even though prevalence of drug use among young people (age 15-24) can be similar or higher than among adults.[118] Young people who use drugs should have access to harm reduction, drug treatment, and HIV services, in line with the recommendations of the UN Committee on the Rights of the Child,[119] yet young people typically are offered only abstinence-based treatment rather than full package of harm reduction services. Even when services are available, young people are unlikely to be aware of them.[120]

[iv] "Addressing chemsex, especially for key populations and their sexual partners, requires a comprehensive, non-judgemental and person centred approach. This can include integrated sexual and reproductive health, mental health, access to sterile needles and syringes and OAMT services, with linkages to other evidence-based prevention, diagnostic and treatment interventions." Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2022 (https://www.who.int/publications/i/item/9789240052390), p33.

67. Laws and policies may require adolescents to obtain parental consent to access services. Data from 2022–2024 show that:

    - only 12 of 76 reporting countries had laws permitting adolescents to access naloxone. Seven of those 12 countries reported that parental consent was required;
    - 13 of 78 reporting countries stated that their laws allowed adolescents to access needle and syringe programmes; six of those countries reported that parental consent was required;
    - 21 of 79 reporting countries stated that their laws allowed adolescents to access opioid agonist maintenance therapy; 14 of those countries reported that parental consent was required.[121]

68. Women's use of drugs is often perceived to violate gender norms around motherhood, partnership and caregiving, which can lead to women who use drugs facing additional stigma and specific harms such as losing custody of their children. Punitive laws and policies, harmful gender norms and stereotypes, gender-based violence, gender inequalities, marginalization, over-incarceration and other service barriers amplify the risk of HIV acquisition for women and people of diverse gender identity and expression who use drugs.[122]

69. One third of women in prison globally are in prison for drug-related offences.[123] Women who inject drugs are often not in a position to negotiate safe injecting practices. They may be more exposed to sexual transmission through sex work if they are unable to negotiate safer sexual practices. They may also face abuse from police and intimate partners, and experience physical or sexual violence.[124] Policy and programming are not sufficiently addressing these interconnections.

Documenting the impacts of criminalization in Latin America

In 2024, the Latin American and Caribbean Network of People Who Use Drugs conducted a community-led regional study across ten countries to examine experiences of people living with HIV who use drugs. They used a mixed-methods approach which included reviewing 590 legal and policy instruments and collecting 557 primary data sources through questionnaires and interviews.

Findings revealed systematic discrimination in health, education, and employment; arbitrary detention and police violence; lack of public harm reduction frameworks and financing; and widespread barriers to accessing HIV, tuberculosis, viral hepatitis, and mental health services. The study provided robust evidence that criminalization is a central structural driver of exclusion and health inequities.

The network's research offers an evidence-based roadmap for strengthening HIV responses through decriminalization of possession for personal use, establishment of legal and budgetary frameworks for harm reduction, mandatory training of state actors, and sustained investment in community-led monitoring, accountability, and participation.

– *Case study submitted by the Latin American and Caribbean Network of People Who Use Drugs*

Trends and gaps in funding the HIV response for people who use drugs

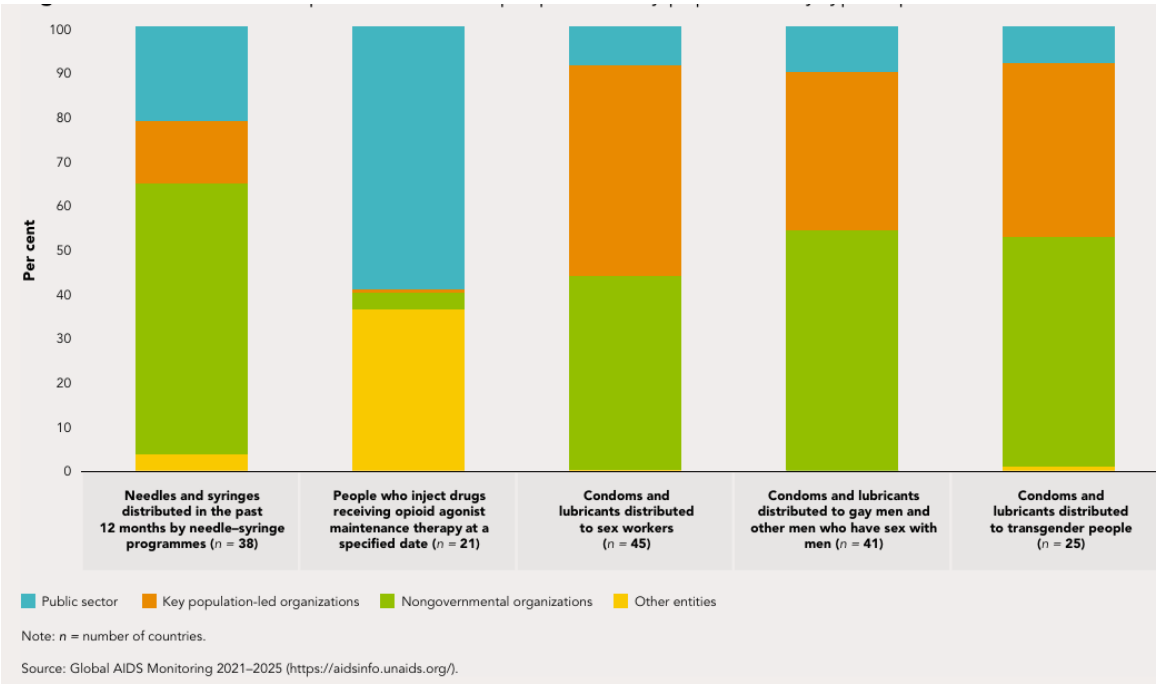
70. Official Development Assistance provided by donor governments has been reduced drastically in recent years. The cuts reflect changing donor policies, including declining support for global health and shifts toward other domestic and international investment

priorities. These changes have led to the reprioritization of scarce HIV resources, resulting in setbacks to the HIV response for people who use drugs in some countries and placing the sustainability of harm reduction programmes under increased threat.[125]

> *The gutting of organizational capacity of community-led service provision has forced severe service disruptions, shortened service hours, the complete closure of services and organizations, and mass job losses for the essential harm reduction workforce—outreach personnel, peer educators, and clinic staff. […] Scarcities in harm reduction supplies and shrinking access to opioid agonist treatment (OAT, i.e. buprenorphine and methadone) have placed community members at heightened threat of multiple and intersecting drug-related harms, including unsupervised withdrawal, unsafe drug use, and heightened experiences of violence, harassment, and overdose.*
> - INPUD report on rapid assessments of the results of 2025 funding cuts.[126]

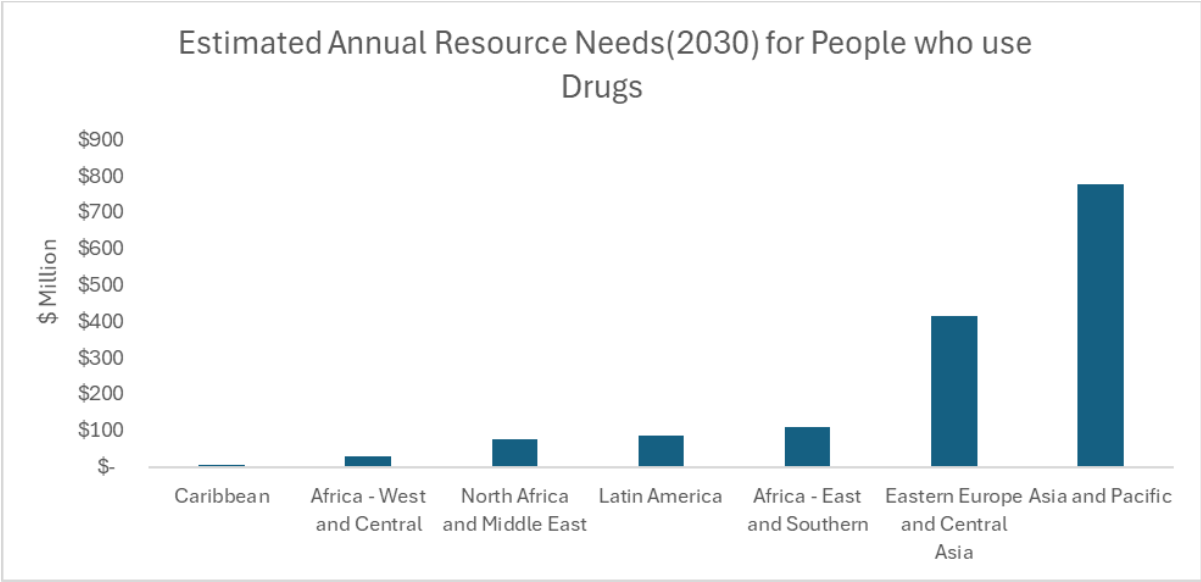
71. In some countries, people from key populations are almost entirely reliant on community-led organizations for vital HIV services and support. According to data recently reported to UNAIDS, 10–45% of people from key populations reached with tailored HIV prevention services were receiving them from key population-led organizations. A further 33–51% relied on other nongovernmental organizations (NGOs) for the services. In the countries reporting these data to UNAIDS, more than 80% of sex workers, gay men and other men who have sex with men, and transgender people relied on NGOs, including those led by people from key populations, for condoms and lubricants. For people who inject drugs, the public sector was a minor source of needles and syringes, but the largest provider of opioid agonist maintenance therapy.[127]

Figure 8. HIV services provided by key population-led organizations



72. Even before recent reductions in donor support, harm reduction funding was inadequate, with less than 1% of total HIV spending allocated to people who inject drugs.[128] This is not commensurate with their disproportionately high risk and contribution to new infections. Funding was already falling prior to 2025, having halved in real values between 2007 and 2022.[129]

Figure 9. Projected resource needs for harm reduction services, by region, 2030



Source: UNAIDS resource needs estimates to achieve 2030 GLOBAL targets, 2025

Human rights approaches to addressing inequalities

Advances and setbacks

73. There have been advances in legal recognition of harm reduction approaches internationally, with the 2025 Human Rights Council resolution on the human rights implications of drug policy,[130] and the 2024 Commission on Narcotic Drugs adopting a resolution recognizing "harm reduction" for the first time.[131] Harm reduction is now explicitly recognized within UN human rights and drug policy frameworks, including in the UN Common Position on Drug Policy, adopted in 2018.[132] UNAIDS, UNDP and INPUD have produced a new guidance note on decriminalization of drug use, providing a powerful normative reference point for the response.[133]

74. At national level, 112 countries now make explicit supportive references to harm reduction in national policy documents, more than ever before. In 2025, Viet Nam removed the death penalty for certain drug-related offenses, reducing the number of drug-related crimes punishable by execution. In Nigeria, opioid agonist therapy programmes have been introduced, bringing to 95 the number of countries where at least one opioid agonist therapy programme operates. And at least one naloxone peer distribution programme is now operational in Nigeria.[134]

75. However, there have also been substantial setbacks. In 2025, a record number of people were executed for drug-related offences: 1,212, up from 615 in 2024, and almost half of all executions globally. Two countries, Algeria and the Maldives, revised their laws to introduce the death penalty for drug offences.[135] Movements opposed to gender rights, human rights, and democracy are adopting moralistic and punitive approaches to drug use. Shrinking civic space directly affects service delivery and community organizing.[136]

76. Contradictory trends are evident in several countries. In Australia, for example, New South Wales state introduced drug checking services,[v] while Queensland banned them. In Mexico, the national government strengthened prohibitionist approaches, while the Mexico City administration authorized designated cannabis consumption zones, with public support services.[137]

77. Some countries that criminalize drugs also implement harm reduction measures—a stark contradiction between public health-oriented responses aimed at reducing harm and punitive legal frameworks that impose severe criminal penalties.[138] Despite their punitive legal environments, Egypt, Kenya and Nigeria have advanced harm reduction.

78. Ongoing advocacy in Kenya, including by community leaders, has pushed for policy reform, culminating in the 2025 National Harm Reduction Bill, which aims to institutionalize harm reduction as a public health obligation. In Egypt, growing recognition within government that harm reduction supports public health goals, and multisectoral collaboration between harm reduction implementers and law enforcement authorities are beginning to influence police practices and have opened space to discuss reforms.[139] However, these advances remain fragile: punitive legal frameworks

[v] Drug-checking services test drugs for contents and sometimes also potency, a harm reduction measure better informing individuals about the drugs they plan to use.

and criminalization continue to pose significant barriers to the scale up, accessibility and sustainability of harm reduction services.[140]

79. There is no evidence that forced drug treatment is effective.[141] On the contrary, it has been linked to negative health outcomes, including increased risk of overdose or death.[142] [143] Involuntary drug treatment, even if mandated by court judgements, violates human rights and should be avoided.[144] [145] [146]

What works? Human rights-based policies

80. Rights-based policies respect and protect rights, and improve outcomes, including de jure and de facto decriminalization models and alternatives to criminal sanctions in diverse national legal frameworks. Decriminalization of drug use and possession for personal use is associated with improved health, reduced rates of HIV transmission and the promotion of social inclusion.[147]

81. The International Guidelines on Human Rights and Drug Policy was developed by a coalition of UN Member States, WHO, UNAIDS, UNDP and leading human rights and drug policy experts in 2020. The guidelines provide a comprehensive set of international legal standards for placing human dignity and sustainable development at the centre of Member States' responses to illicit drug economies. It is a tool for integrating international human rights commitments related to drug policy into national, regional and global policy and programmes.[148]

82. In March 2026, UNAIDS, UNDP and INPUD published the *Decriminalization of drug use in the context of HIV: a guidance note*. This guidance note draws together lessons learned from different models and approaches to the decriminalization of drug use and possession for personal use, while analysing their efficacy in relation to HIV outcomes. It is intended to support countries to develop effective, public health and rights-based models of decriminalization in the context of HIV. The note promotes diversity in decriminalization models and identifies key common considerations, including:

    - how to define drug use "for personal use"–including the role of threshold quantities and other approaches;
    - the role of law enforcement, judiciary and other actors in a decriminalization model, and the need to limit unnecessary interaction with law enforcement such as "stop and search", to train law enforcement officers and ensure strong oversight mechanisms; and
    - alternatives to criminal sanctions since a "no-sanctions" model with voluntary treatment options has the best chance of achieving positive public health and human rights outcomes.

83. In the early 2000s, Portugal decriminalized drug possession for personal use and treated drug dependence as an illness, providing extensive treatment and recovery support. From 2001 to 2017, the number of people using heroin fell from an estimated 100 000, to 25 000; fatal overdoses decreased by more than 85%, and new HIV diagnoses by more than 90%. In recent years however, a fall in funding for the drug treatment programme has coincided with an increase in substance use.[149]

Addressing human rights violations in India

Coercive practices such as involuntary, non-consensual treatment and discrimination within drug dependence services undermine the rights, dignity and health of people who use drugs and deter access to HIV services.

The Indian Drug Users' Forum led a community-driven, rights-based initiative to document such violations in drug treatment settings. Trained community members generated evidence on service denial, stigma and abusive practices, which was then used to inform advocacy with HIV, health and social justice authorities. The initiative strengthened awareness of rights and entitlements among communities, improved accountability of service providers, and challenged practices inconsistent with rights-based legislative frameworks such as the Mental Healthcare Act (2017).

– Case study submitted by the Indian Drug User's Forum

What works? Community leadership

84. Communities play a vital role in service provision. Community-led networks and groups know how to reach people who use drugs, build trust and make services accessible to them.[150] [151] Most people who use drugs, especially but not only those living in countries that criminalize drug use or possession, have little trust in health systems, and will not access harm reduction without community intermediaries.

Community-led harm reduction for women who use drugs in Mombasa, Kenya

In Mombasa County, Kenya, a community-led, gender-responsive harm reduction model implemented by the Kenya AIDS NGOs Consortium has contributed to reducing health inequities.

While needle and syringe programmes, opioid agonist therapy, and overdose prevention interventions are available in Kenya, they often have been underutilized by women because of the male-centred character of service models, limited childcare options, and fears of legal consequences, including the loss of child custody. In addition, emerging patterns of sexualized drug use have been insufficiently addressed.

Between 2022 and 2025, the intervention achieved a 40% increase in women's access to needle and syringe programmes and more than doubled enrolment in opioid agonist therapy. Non-injecting drug users have also increased engagement with services. These outcomes were driven by the involvement of female peer outreach workers; the introduction of flexible clinic hours and expedited enrolment for pregnant and breastfeeding women; the integration of harm reduction services with HIV testing and ART; the distribution of naloxone accompanied by overdose prevention training; and targeted responses to sexualized drug use, including HIV prevention, STI screening, and risk-reduction counselling.

- Case study submitted by Kenya AIDS NGOs Consortium

85. Community leadership includes community involvement in service delivery, governance and decision-making, and monitoring and accountability mechanisms. This goes beyond participation in service design and delivery, and includes institutionalized participation in governance at community and national levels.[152] [153]

Youth leadership in Indonesia

In Indonesia, the youth-led Inti Muda network has influenced national harm reduction and HIV programming by securing meaningful participation in Global Fund programme reviews and country dialogue processes.

Through sustained advocacy, Inti Muda shaped the design of harm reduction and HIV outreach modules and was invited to present its work at the HIV Joint Programme Review. Its continued engagement in the 2026 Country Dialogue demonstrates how institutionalized participation of young people who use drugs can strengthen community-led, peer-based harm reduction within national HIV responses.

– Case study submitted by Youth Rise

What works? Addressing stigma, discrimination, and violence

86. Stigma, discrimination and violence obstruct effective responses to drug use. Interventions addressing stigma, discrimination and violence, such as safe spaces, community organizing, educating service providers, policy advocacy, and economic inclusion,[154] can be impactful in diverse legal contexts.

87. Service providers need training on recognizing and eliminating stigma and discrimination. Of 73 countries with available data, 51 reported that healthcare workers received government-provided training on human rights and non-discrimination relating to people who inject drugs in at least 25% of provinces, regions or districts.[155]

88. The majority of harm reduction programmes are targeted at adult men and therefore tend to exclude women, gender-diverse people and young people.[156] Gender-responsive interventions that target women and gender-diverse individuals and address the overlap between drug use, sexual health risks and gender based violence have been shown to have positive health outcomes.[157]

89. Youth-responsive services that adopt pragmatic harm reduction rather than protective or punitive approaches, particularly those led by young people key populations, have been shown to be effective. Since digital cultures are a big part of young people's lives, and play a particular role in chemsex, harm reduction initiatives for young people need online engagement.

Non-judgemental youth-responsive chemsex intervention in Cambodia

In Cambodia, a community-led, youth-responsive harm reduction approach has strengthened the HIV response among young gay men, other men who have sex with men, transgender women, and sex workers engaged in sexualized drug use (chemsex).

Following evidence generated through a national operational study on chemsex-related risks, the community-led organization Men's Health Cambodia implemented tailored outreach and service adaptations that integrated harm reduction, HIV testing, PrEP, and mental health support, including through digital platforms commonly used by young people.

In Phnom Penh, the pilot intervention reached 800 young chemsex users at its start in 2024, achieving high linkage to ART among those diagnosed with HIV, and increased PrEP uptake among those testing negative. Between 2024 and 2025, HIV testing uptake increased alongside improved linkage to prevention and treatment services.

Building on these outcomes, Cambodia developed national operational guidelines on integrated HIV, harm reduction, and mental health services for key populations at risk of chemsex, providing a standardized framework to scale up youth-responsive, community-led interventions within the national HIV response.

– Case study submitted by National Center for HIV/AIDS, Dermatology and STD

Climate change, conflict, war, humanitarian crises and displacement

90. There are many connections between climate change, conflict, humanitarian crises, displacement and drug use. Drug production and its environmental impacts are often concentrated in ecologically sensitive regions such as protected areas, forests and indigenous lands.[158] Climate change, conflict, humanitarian crises and displacement can render people's environments less liveable and damage their psychological and physical health, while substance use can become a coping strategy in such circumstances.[159] Combatants and ex-combatants also report increased use of drugs.[160] People who use drugs and other key populations face stigma, discrimination and legal barriers that limit their access to healthcare, which make them even more susceptible to the compounded effects of climate change, instability, and HIV,[161] and make it even harder to access health care systems disrupted by war and crises.

91. Ukraine offers some lessons for sustaining harm reduction during wars and conflict (see box below).

Engagement of women who use drugs in the humanitarian response in Ukraine

In Ukraine's war-driven, protracted humanitarian crisis, women who use drugs face acute health and protection risks driven by displacement, poverty, gender-based violence, and systemic stigma. Disrupted healthcare systems, fear of law enforcement engagement, and the risk of child separation lead many women to delay or avoid care, leaving them effectively excluded from humanitarian support and harm reduction.

To address these gaps, the All Ukrainian Association of Women Who Use Drugs, with support from the Alliance for Public Health and funding from L'Initiative (Expertise France), established "Mother and Child Rooms" and a "Green Room" as stigma-free humanitarian safe spaces integrated within harm-reduction programming.

Operating in Kyiv, Dnipro, Lviv, Odesa, and Kryvyi Rih, the Rooms provide gender-responsive, crisis-adapted services including HIV and STI testing, sexual and reproductive health care, mental health and psychosocial support, violence response, legal assistance, and humanitarian aid. More than 800 women receiving opioid agonist therapy have accessed integrated services, with child-friendly spaces enabling women to seek care without risking separation from their children. The intervention strengthens service continuity during crisis, improves retention in opioid agonist therapy, and reduces HIV and STI risks while restoring safety, dignity, and access to lifesaving care for women otherwise excluded from humanitarian responses.

– Case study submitted by the All Ukrainian Association of Women Who Use Drugs

92. Use of substances such as alcohol, opiates or tranquilizers is common in some displacement settings. Displaced communities may continue or exaggerate

predisplacement patterns of drug use, adapt to host population drug use patterns, or be a mix of the two.[162] Patterns vary among displacement settings, for example drug use can be higher among displaced populations living in urban refugee camps than among refugees living in community settings.[163]

> [In refugee settlements] *Humanitarian actors are often the first and sometimes only point of contact for affected individuals, yet many remain under-equipped to recognize and respond to substance-related conditions*
>
> – Mukasa Moses Bwesige, Inter Regional Mental Health and Psychosocial Support officer at Jesuit Refugee Service, Uganda.[164]

93. Criminalization of people who use drugs and of homelessness can lead to displacement, for example in the US and Canada, police have conducted "street sweeps", expelling people from particular areas, including by destroying their temporary shelters. These interventions are associated with increased health risks, including greater risk of overdose.[165] [166] In Canada in 2024, drug use was recriminalized in most urban public spaces, leading to "ongoing forced displacement from public spaces". According to one person who uses drugs, the "VPD [Vancouver Police Department] was pushing us around a lot when we were camping places … and it was very destructive, very belittling ... Couldn't set up camp anywhere or tent anywhere and you had to take it down..."[167]

94. Humanitarian efforts must address the needs of people who use drugs and collaborate with communities and harm reduction services, using a systems approach, with multiple sectors and several levels of engagement. Advocacy is needed to include harm reduction services in humanitarian responses. More research is needed on drug use in humanitarian settings and how to effectively organize responses with strong community engagement.

95. Initiatives are needed to mitigate climate change impacts and other crises. They should be inclusive of people who use drugs, such as affordable housing, access to green spaces, food security programmes, open public shelters, and the development of social networks and peer support. Specific measures addressing the needs of people who use drugs also should be part of emergency planning, for example continuity of care, including access to medication during disasters, and outreach during heatwaves to which people who use alcohol, opioids and stimulants may be more physically vulnerable.[168]

96. The Inter-Agency Standing Committee on Mental Health and Psychosocial Support in Emergency Settings has established a dedicated thematic group on substance use, co-chaired by WHO, the UN Office on Drugs and Crime (UNODC) and the Office of the UN High Commissioner for Refugees (UNHCR). The Committee's guidelines on mental health and psychosocial support in emergency settings can be used to help plan, establish and coordinate emergency preparedness, and minimum and comprehensive multisector responses to protect, support and improve people's mental health and psychosocial well-being in emergencies, including specified action for guidance on minimizing harm related to alcohol and other substance use.[169] WHO and UNHCR have developed tools to assess substance use in emergency settings, which have been used in several countries.[170]

97. The Committee also launched a new initiative to transform humanitarian responses approaches to substance use. They have developed interactive training materials for humanitarian workers to challenge stigma and to shift from treating substance use disorder as a moral failing to approaching it as a public health issue. Between 2024 and 2025, the materials were field tested with 342 frontline workers in Afghanistan, Iraq, Myanmar, Somalia, South Sudan, Syria and Uganda; they will be updated in accordance with the feedback. The pilot shifted attitudes towards more humane and evidence-based approaches to drug use. [171]

Sustainable futures

Addressing the funding crisis through sustainable solutions

98. Strengthening domestic investment in harm reduction and integration into national health systems is now essential to ensure the continuity of services and the protection of public health gains.[172] Community-led monitoring and analyses are hugely important to identify the impacts of funding cuts and priorities for investment.

Domestic funding of integrated community-led services in South Africa

The Community-Oriented Substance Use Programme in Tshwane, South Africa, offers a viable model for sustaining harm reduction through domestic financing and social contracting.

Established through a partnership between the City of Tshwane and the University of Pretoria's Department of Family Medicine, the programme applies a community-oriented primary care approach to injecting drug use. It integrates harm reduction, human rights, and community participation into a comprehensive continuum of care, delivering opioid agonist therapy, needle and syringe programmes, HIV and hepatitis prevention, psychosocial support, and vocational services. Municipal funding is channelled through the Department of Health to the University of Pretoria, which sub-contracts community-led organizations to implement core service components, ensuring both institutional sustainability and meaningful community leadership.

The programme has shown strong resilience and public health impact, including during periods of crisis and donor withdrawal. During the COVID-19 national lockdown, all its sites remained operational, with over 2,000 new clients reached and 1,076 people initiated on methadone, including daily, observed dosing for more than 500 individuals across 26 shelters.

More broadly, the programme now delivers almost half of all harm reduction services in South Africa. Between 2020 and 2023, almost 2,500 people who inject drugs were initiated on opioid agonist therapy, and over 60 000 sterile needles were distributed per month. Independent assessments show improved health outcomes, strengthened community integration, and reduced stigma, with over 80% of stakeholders reporting positive impacts for service users and their communities.

While challenges remain, particularly vulnerability to political change and declining onward funding to community organizations, the programme illustrates how domestically financed, community-integrated harm reduction can safeguard service continuity, absorb donor shocks, and provide a scalable model for national replication.

– Case study submitted by Harm Reduction International

99. Evidence-based approaches for reducing HIV infections and reducing incarceration can also lead to cost-savings,[173] with evidence showing that shifting funding from punitive approaches to harm reduction can be both cost-effective and cost-saving.[174] Yet, many

governments continue to allocate significant funding to criminalizing drug use and imprisoning people for drug use or possession for personal use, rather than investing in evidence-based harm reduction responses that would cut prison and healthcare bills.[175]

100. In Mauritius, 80% of all domestic HIV programming for people who inject drugs and their partners is government funded.[176] Mauritius shifted from a solely punitive approach to drug use to a public health one, introducing opioid agonist treatment in 2006 which was extended into prisons, and expanding needle and syringe programmes.[177] New HIV infections attributed to injecting drug use fell from about 92% in 2005 to 28% in 2024. HIV prevalence among people who inject drugs declined from 52% in 2011 to 21% in 2021.[178] These services are cost-effective: opioid agonist therapy is 11 times cheaper than imprisonment, at an average of US$1-2 per day per person, while the comparable cost of imprisonment runs to an average US$17.[179] [180]

101. In Portugal, after personal possession of all drugs was decriminalized, the social costs of drug use, including costs of criminal proceedings and incarceration, and the indirect health costs associated with drug-related deaths, fell by over 18%.[181] In India, integrated needle and syringe programmes, opioid agonist therapy and wider harm reduction support were found to be cost-effective for HIV prevention, averting 996 HIV infections over three years.[182] A study in Seattle, USA, estimated that establishing a drug consumption room would save US$ 4.22 in associated healthcare costs for every dollar spent on operational costs.[183] The Ministry of Law and Human Rights in Indonesia spent around 42% of its total budget on managing prisons. If Indonesia decriminalized personal possession of small amounts of drugs, the burden on prisons and other closed settings would be reduced by 40%.[184]

Addressing the impacts of shrinking civic space and human rights backlash

102. Legal and policy environments often restrict community organizing by people who use drugs and the provision of harm reduction services by community led organizations. Globally, organizations led by people who use drugs are able to register and legally operate in fewer countries compared with organizations led by other key populations.[185] In addition, community-led organizations' provision of naloxone, needles and syringes is legally restricted in more countries than their provision of condoms, lubricant, HIV testing, legal literacy, and other support.[186]

103. In recent years, a number of countries in Eastern Europe and Central Asia have introduced or expanded legal provisions framed as efforts to "counteract drug propaganda. These broadly defined measures increasingly restrict not only the promotion of drug use, but also the dissemination of information, including advocacy for harm reduction and drug policy reform, and in some cases extend to the depiction of controlled substances, thereby constraining public health communication and civil society engagement.[187]

104. Even when countries have not adopted similar "drug propaganda" laws, criminalization of drugs for personal use makes organizing risky for people who use drugs. Recent crackdowns on civil society organizing, and legal restrictions on international funding in eastern Europe and central Asia further limit possibilities for organizing—for example, through enacting "foreign representatives" laws which mandate a specific and difficult registration process for NGOs receive foreign funding. Several harm reduction NGOs in the region have ceased their advocacy activities and smaller community organizations have shut down pre-emptively.[188]

105. Civil society organizing, including by people who use drugs, is essential not only for HIV responses, but for democracy more broadly.[189] Civil society organizing and legal defense, in whatever ways are safe for activists, must be supported.[190] [191] Where domestically people who use drugs cannot organize and speak out safely, international networks of people who use drugs, such as INPUD and regional networks, play an even more vital roles.

Fostering decriminalization and enabling legal environments in central and eastern Europe and central Asia

In many countries in central and eastern Europe and central Asia, punitive drug laws and enforcement practices criminalize people who use drugs, creating major barriers to HIV prevention and harm reduction. Eurasian Harm Reduction Association's public health policing initiative advances decriminalization in practice by shifting policing from punishment toward health-oriented responses.

Using regional evidence, country profiles in 29 countries and advocacy, the Association documents how arrests, fines, needle confiscation, and police surveillance undermine service access. The initiative develops practical guidance and referral models enabling police to direct people who use drugs to health and social services instead of arrest. By promoting police training on harm reduction and accountability mechanisms, it also demonstrates that decriminalization must be accompanied by changes in enforcement to create enabling legal and operational environments for effective HIV responses.

– Case study submitted by Eurasian Harm Reduction Association

106. The roles of UN agencies are more important than ever, including for publicizing the evidence that ending the criminalization of drug use and possession, and promoting the leadership and engagement of communities of people who use drugs in HIV responses protect health, save lives and are cost-effective. With support from the UN Human Rights' Office and UNODC, the Philippines has made some positive policy shifts, strengthening government support for establishing an independent forensic institute to investigate potentially unlawful deaths, including drug-related killings, and supporting women widowed by such acts.[192]

Placing harm reduction within the sustainability, transition and integration agendas

107. Integration into national health systems is essential to ensure the sustainability of harm reduction. Harm reduction needs to be institutionalized in national health strategies. Integration can facilitate joined up broader health services for people using drugs.[193] Where services are effectively integrated, they can better meet the needs of women and key populations.[194] Integrating sexual and reproductive health and harm reduction services, has seen increased engagement in both.[195] A community-led, person-centred approach to integration is essential to address the intersecting drivers of HIV risk among people who use drugs, improve access to services and sustain health outcomes over time. Social contracting can be a productive mechanism to support community leadership in harm reduction.

108. Integration is not simply the incorporation of HIV and harm reduction services into primary healthcare systems. Community-led integrated HIV services deliver HIV prevention, testing, treatment, and care alongside the broader health and social services that individuals require to initiate, access and sustain care. Integration, in this sense, reflects the lived realities of people who use drugs, whose needs are shaped by

intersecting structural determinants and cannot be addressed through siloed service delivery.[196]

> Integration, as understood by communities, is inherently intersectional: it recognizes that people experience HIV risk and barriers to care through multiple, overlapping determinants, such as gender identity, sexuality, criminalization, poverty, violence and migration status, and therefore require services that respond to the whole person rather than a single issue. This means delivering HIV care alongside gender-affirming services, sexual and reproductive health and rights, harm reduction, mental health and psychosocial support, legal aid, gender-based violence response, food and housing assistance, and peer accompaniment. It amounts to more than the co-location of services: it is a holistic, person-centred, stigma-safe care "journey" that is grounded in trust, confidentiality and cultural safety, with peer leadership at every stage.
>
> – Community-led integrated HIV services: The future of a sustainable HIV response, NGO REPORT UNAIDS/PCB (57)/25.28, 16–18 December 2025. p4-5[197]

109. Integration should be understood as a complementary and coordinated ecosystem of services, in which community-led organizations play a central role as essential providers, rather than being absorbed into formal health systems. Evidence demonstrates that community-led services are often best placed to reach people who use drugs, particularly those experiencing marginalization, due to their ability to provide trusted, non-judgmental, and context-specific support. Importantly, integration should not result in the dilution, medicalization, or loss of community-led approaches. It should strengthen and sustain them, including through formal recognition, adequate and predictable financing, and supportive legal and policy environments.[198]

> Community-led services are not a temporary solution to be absorbed and phased out. They are a permanent, essential part of effective and rights-based health systems. Integration that weakens peer leadership, cuts harm reduction, or sidelines drug user-led organizations is not progress, it is regression. We must ensure that integration happens with us, not to us.
>
> – Anton Basenko, Executive Director, International Network of People who Use Drugs[199]

110. Effective integration requires continuity of care across different settings and life situations, including transitions between community and clinical services, and across contexts such as incarceration, migration, and humanitarian crises.

111. What does community-led integration look like in practice? Common evidence-based modalities include:

- One-Stop Community Health Hubs offering HIV testing, TB symptom screening, malaria rapid diagnostic testing, SRHR services, and primary care navigation in a single location, best led by community members themselves;
- Integrated peer navigation with health workers and peers accompanying service users across the health system, which is particularly useful for people who face multiple service barriers;
- Community-led monitoring platforms which collect, synthesize and report data on integrated service quality, coverage gaps, and equity outcomes, thereby also supporting learning and holding services to account;

112. Linkage and retention networks of community organizations that create welcoming referral pathways across programs, ensuring that people who test positive for HIV are connected to TB preventive therapy, TB patients are offered HIV testing, and pregnant women receiving malaria prophylaxis are enrolled in services for preventing vertical transmission of HIV.[200]

Domestically funded integration of opioid agonist therapy into the public healthcare system in Albania

Opioid agonist therapy was introduced in Albania in 2000 as a low-threshold, community-based intervention. Since then, opioid agonist therapy services were delivered by NGOs with Global Fund support, ensuring access while operating largely outside the public health system but remaining donor dependent.

In late 2023, Albania undertook a major policy shift by integrating opioid agonist therapy into the public healthcare system and transitioning to domestic financing, aligning harm reduction with national commitments to universal health coverage, sustainability of the HIV response, and equity for key populations.

The transition represents a significant structural reform, with the government assuming responsibility for service delivery, staffing, and procurement of methadone. By 2024, the number of opioid agonist therapy service sites increased from 9 to 13 nationwide, including integration into the prison health system. The shift has strengthened coordination, referral pathways, and linkage to the HIV cascade, moving from a project-based model to a people-centred, system-integrated approach supported by standardized national protocols and the Action Plan for Drug Prevention, Treatment and Harm Reduction (2023–2026).

As a result, Albania has improved the sustainability and geographic equity of opioid agonist therapy services, currently reaching 726 people in the wider community and 128 people in prisons. While challenges remain—including limited treatment coverage relative to need and restricted pharmacological options—the transition demonstrates how domestic financing and public-system integration can enhance resilience, reduce reliance on external donors, and support a more sustainable, rights-based HIV response, with ongoing civil-society engagement remaining essential for outreach, quality, and community trust.

– Case study submitted by Institute of Public Health, Government of Albania

Recommendations: Harm reduction in a changing world

113. A set of core recommendations emerge from the evidence summarized in this paper.

- Recognize and fund harm reduction as an essential, evidence-based, rights-affirming and cost-effective component of the HIV response to accelerate progress towards achieving the global AIDS targets on prevention, ending stigma and discrimination, integration and community leadership. For that purpose:
- **Account for the needs of people who use drugs in their diversity, including women and youth, LGBTI persons, sex workers, people in humanitarian settings and people in prisons**. Countries should ensure that harm reduction responses are tailored to the diverse realities of people who use drugs, recognizing that HIV risk and access to services are shaped by intersecting structural factors including gender inequality, age, sexual orientation and gender identity, incarceration, displacement and humanitarian crises. Heightened stigma, violence and legal barriers faced by women, young people, gender-diverse individuals, and people in prison and humanitarian settings who use drugs should be addressed through differentiated,

gender- and youth-responsive approaches, including the integration of harm reduction into prison health services and humanitarian responses to ensure equitable access and improved health outcomes for all groups.

- **Integrate harm reduction into national budgets and health systems, in ways that strengthen and sustain community leadership, including through social contracting.** Sustained progress towards the global AIDS targets requires the integration of harm reduction into national health systems and domestic financing frameworks, moving towards institutionalized, people-centred models of care. Integration should be undertaken in ways that reinforce community-led service delivery, recognizing the critical role of organizations led by people who use drugs in ensuring trust and service accessibility. Mechanisms including social contracting should be developed and scaled-up to provide public finance for community-led organizations, while integrated service delivery can improve linkage across HIV, viral hepatitis and broader health and social services.
- **Remove criminal sanctions for drug use and possession for personal use to improve access to HIV services.** Countries are urged to remove criminal sanctions for drug use and possession for personal use and adopt public health and human rights–based approaches, recognizing that criminalization and stigma undermine access to HIV services, while decriminalization improves health outcomes and service uptake. Aligning national legal frameworks with the latest international guidance can reduce harm, decrease incarceration and create enabling environments for effective HIV responses, contributing directly to targets on eliminating stigma and discrimination and reducing punitive laws.
- **Ensure that organizations led by people who use drugs and wider civil society which are engaged in harm reduction advocacy, service delivery and accountability processes can freely register, operate and apply for domestic and international funding.** Shrinking civic space, legal barriers and funding constraints undermine community-led service delivery, advocacy and accountability, despite strong evidence that such organizations are central to reaching underserved populations and monitoring the quality and equity of services. To sustain effective harm reduction programmes, maintain service continuity and advance gains in HIV responses, countries should support community leadership, including through legal protection, financing and capacity strengthening. Countries should ensure that organizations led by people who use drugs, including women and young people, and broader civil society can freely register, operate and access both domestic and international funding.
- **Collect and use disaggregated data, including community-generated data, to understand gaps in services and support decision-making on planning of HIV services for people who use drugs and targeted investment in harm reduction**. Countries should strengthen strategic information systems by collecting and using high-quality, disaggregated data on people who inject and use drugs, including by age, gender and other relevant characteristics, to better understand service gaps and guide targeted investments. Countries should also support collecting and using community-generated data, including through community-led monitoring, to better capture lived realities, identify barriers to access and strengthen accountability within the HIV response. Expanding the availability, quality and use of such data will enable more effective planning, resource allocation and tracking of progress towards global targets, while ensuring that responsiveness to the needs of those most affected by HIV.

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