UNAIDS I **2019**

HEALTH, RIGHTS AND DRUGS

HARM REDUCTION, DECRIMINALIZATION AND ZERO DISCRIMINATION FOR PEOPLE WHO USE DRUGS

CONTENTS

FOREWORD

In 2016, UNAIDS published a landmark report on HIV and drugs. That report—*Do no harm: health, human rights and people who use drugs*—showed how the world was failing to protect the health and human rights of people who use drugs, and it provided a road map for countries to reduce the harms that are associated with drug use, and to turn around their drug-related HIV epidemics.

Three years later, this report, *Health, rights and drugs: harm reduction, decriminalization and zero discrimination for people who use drugs*, shows that people who use drugs are still being left behind. New HIV infections among adults worldwide declined by 14% between 2011 and 2017, but there has been no decrease in the annual number of new HIV infections among people who inject drugs. This is unacceptable: people who use drugs have rights, and too often these rights are being denied.

In 2016, I wrote that "Business as usual is clearly getting us nowhere" and called for countries to learn lessons from those that had reversed their HIV epidemics among people who inject drugs. Despite this, too many countries are failing to learn those lessons and carrying on with business as usual. As a result of the current global approach, persistently high rates of HIV, viral hepatitis and tuberculosis continue among people who inject drugs.

We know what works. There is compelling and comprehensive evidence that harm reduction—including opioid substitution therapy and needle–syringe programmes—improves the health of people who inject drugs. It is safe and cost-effective. Additionally, when people who use drugs have access to harm reduction services, they are more likely to take an HIV test, and if found to be living with HIV, enrol in and adhere to HIV treatment.

Decriminalization of drug use and possession for personal use reduces the stigma and discrimination that hampers access to health care, harm reduction and legal services. People who use drugs need support, not incarceration.

I've seen what works: an opioid substitution programme in Minsk, Belarus, that helps people dependent on opioids live with dignity; and a health centre in Saskatoon, Canada, that provides sterile injecting equipment so that people who inject drugs can prevent the spread of HIV, viral hepatitis and other blood-borne infections. Such enlightened and effective programmes should be available wherever and whenever there is a need. Sadly, they are the exceptions, and policies that criminalize and marginalize people who use drugs are too often the rule.

The time is overdue to revisit and refocus the global approach to drug policy, putting public health and human rights at the centre. I've said it before and I will say it again: if we are to end AIDS by 2030, we can't leave anyone behind. And that includes people who use drugs.

Michel Sidibé
UNAIDS Executive Director

INTRODUCTION

"AT THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON THE WORLD DRUG PROBLEM . . . GOVERNMENTS CAME TOGETHER TO CHART A NEW PATH FORWARD THAT IS MORE EFFECTIVE AND HUMANE, AND LEAVES NO ONE BEHIND . . .

"IT IS VITAL THAT WE EXAMINE THE EFFECTIVENESS OF THE WAR-ON-DRUGS APPROACH AND ITS CONSEQUENCES FOR HUMAN RIGHTS. DESPITE THE RISKS AND CHALLENGES INHERENT IN TACKLING THIS GLOBAL PROBLEM, I HOPE AND BELIEVE WE ARE ON THE RIGHT PATH, AND THAT, TOGETHER, WE CAN IMPLEMENT A COORDINATED, BALANCED AND COMPREHENSIVE APPROACH THAT LEADS TO SUSTAINABLE SOLUTIONS."

UNITED NATIONS SECRETARY-GENERAL **António Guterres** 26 June 2017

People who use drugs have been the biggest casualties of the global war on drugs. Vilified and criminalized for decades, they have been pushed to the margins of society, harassed, imprisoned, tortured, denied services, and in some countries, summarily executed. Billions of dollars spent, a considerable amount of blood spilt and the imprisonment of millions of people have failed to reduce either the size of the drug trade or the number of people who use psychoactive substances *(1)*.

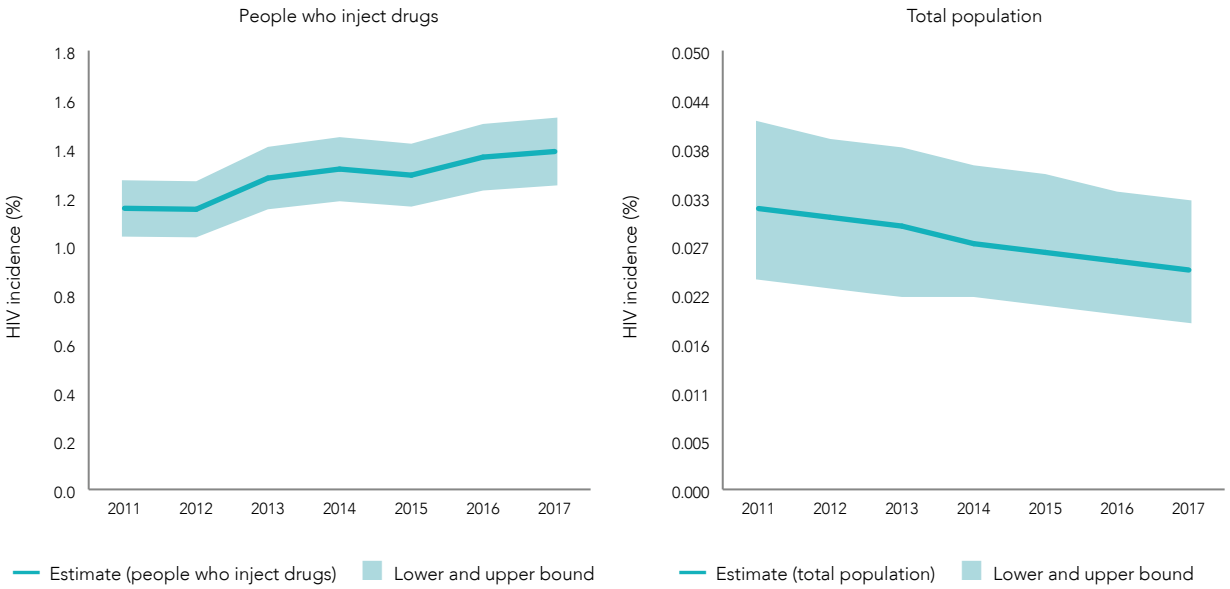
Amid the widespread stigma and discrimination, violence and poor health faced by people who use drugs, people who inject drugs are beset by persistently high rates of HIV. While the incidence of HIV infection globally (all ages) declined by 25% between 2010 and 2017, HIV infections among people who inject drugs are rising (Figure 1). Outside of sub-Saharan Africa, people who inject drugs and their sexual partners account for roughly one quarter of all people newly infected with HIV. In two regions of the world—eastern Europe and central Asia, and the Middle East and North Africa—people who inject drugs accounted for more than one third of new infections in 2017. Viral hepatitis and tuberculosis rates among people who use drugs also are high in many parts of the world. These preventable and treatable diseases, combined with overdose deaths that are equally preventable, are claiming hundreds of thousands of lives each year.

This is a problem that has a clear solution: harm reduction. Study after study has demonstrated that comprehensive harm reduction services—including needle–syringe programmes, drug dependence treatment, overdose prevention with naloxone, and testing and treatment for HIV, tuberculosis, and hepatitis B and C—reduce the incidence of blood-borne infections, problem drug use, overdose deaths and other harms. Countries that have successfully scaled up harm reduction have experienced steep declines in HIV infections among people who inject drugs.

Armed with this overwhelming evidence, grass-roots organizations of people who use drugs, harm reduction and human rights advocates, and allied nongovernmental organizations have played a leading advocacy role on harm reduction. Civil society organizations also are instrumental in the delivery of harm reduction services, often through trusted peer outreach workers.

In 2016, the United Nations (UN) General Assembly held a Special Session on the World Drug Problem. Amid growing calls for a people-

Figure 1. Comparison of incidence of HIV, people who inject drugs and total population (all ages), global, 2011–2017



Note: The scales of the vertical axes in each graph are different. HIV incidence is considerably higher among people who inject drugs compared to the general population. Plausibility bounds for incidence among people who inject drugs are adopted from the new infections' calculated bounds rather than directly estimated.
Source: UNAIDS 2018 estimates.

centred, public health and human rights-based approach to drug use, UN Member States agreed to an outcome document that took an important step forward: it called for effective public health measures to improve health outcomes for people who use drugs, including programmes that reduce the impact of the harms sometimes associated with drug use. The outcome document also underlined the need to fully respect the human rights and fundamental freedoms of people who use drugs, and it called on countries to consider alternatives to punishment for drug offences *(3)*.

A few months after the 2016 Special Session, the UN General Assembly convened a high-level meeting on the global HIV epidemic. The meeting concluded with the 2016 Political Declaration on Ending AIDS that acknowledged people who inject drugs as a key population at high risk of HIV infection who face stigma and discrimination and restrictive laws that hamper their access to HIV services *(4)*. The 2016 Political Declaration on Ending AIDS contains a commitment to "saturating areas with high HIV incidence with a combination of tailored prevention interventions," including harm reduction, and it encourages UN Member States to reach 90% of those at risk of HIV infection with these services *(4)*.

In 2017, the International Narcotics Control Board (INCB) also called for the abolition of the death penalty for drug-related offenses, stressing the importance of human rights and public health principles in drug control *(5, 6)*.

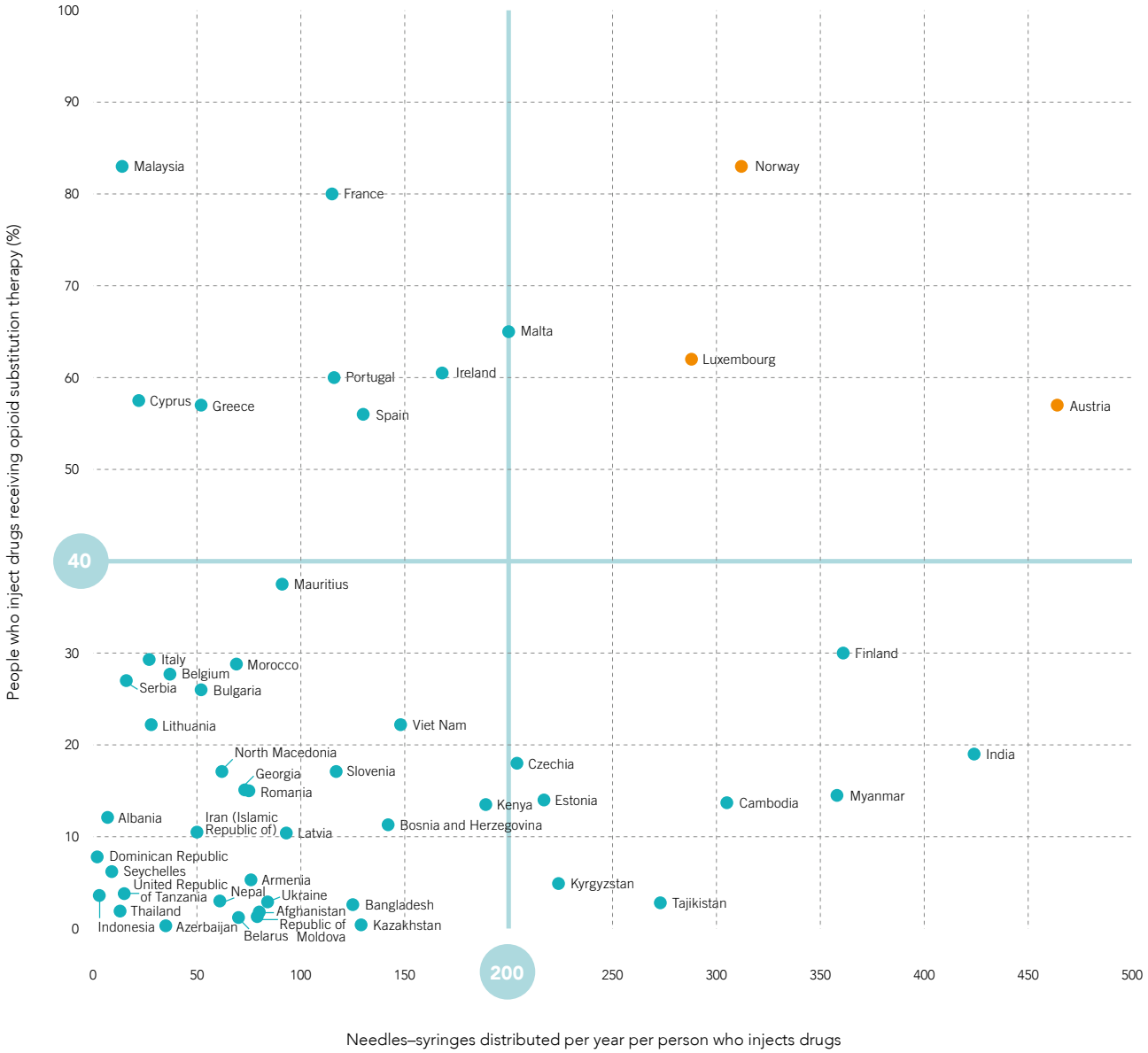
However, change within countries has been slow. Three years after the 2016 Special Session, needle–syringe distribution and opioid substitution therapy coverage remain low in most of the 51 countries that have reported data to UNAIDS in recent years. Just three high-income countries —Austria, Luxembourg and Norway—reported that they had achieved UN-recommended levels of coverage for these programmes (Figure 2). Those three countries are home to less than 1% of the global population of people who inject drugs. A recent systematic review of published harm reduction programme and survey data similarly found that less than 1% of people who inject drugs globally live in countries with sufficient access to these critical harm reduction services *(7)*.

This low coverage is perpetuated by low investment. Only a handful of low- and middle-income countries have reported expenditures to UNAIDS that are sufficient to meet the needs of people who inject drugs. Domestic financing is particularly

"MANY POLICY-MAKERS CONTINUE TO THINK THAT HARM REDUCTION ENCOURAGES DRUG USE, AND [THAT] OPIOID SUBSTITUTION TREATMENT IS ABOUT REPLACING ONE DRUG WITH ANOTHER. IT MEANS THAT MORE ADVOCACY WORK SHOULD BE DONE. AS CIVIL SOCIETY, WE SEE IT AS OUR PREROGATIVE TO WORK WITH THE GOVERNMENTS AND CONVINCE THEM THAT HARM REDUCTION WORKS."

Elie Aaraj, Middle East and North Asia Harm Reduction Network *(2)*

Figure 2. Coverage of needle–syringe programmes and opioid substitution therapy, by country, last year available (2013–2017)



Source: UNAIDS Global AIDS Monitoring, 2013–2017.

low: in 31 countries that reported expenditure data to UNAIDS, 71% of the spending for HIV services for people who use drugs was financed by external donors *(8–10)*.

Even when services are available, criminalization of drug use and harsh punishments discourage their uptake. Punishments can include lengthy prison sentences, heavy fines and, in some cases, even the death penalty. An estimated one in five persons in prison globally are incarcerated for drug-related offenses; approximately 80% of these cases are related to possession alone *(11, 12)*. People in detention often have less access to harm reduction services and face greater risk of HIV, tuberculosis and viral hepatitis transmission, as well as other health risks. Intersecting forms of discrimination and vulnerability related to gender, age and race have different impacts on people who use drugs.

Thirty-five countries retain the death penalty for drug-related offences, and the Philippines has seen thousands of extrajudicial executions of people who use drugs since a national crackdown began in 2016 *(11, 13)*. Some countries have removed criminal laws on drug possession and use, but they instead use administrative laws to detain people who inject drugs in compulsory drug detention centres that have been linked to torture, forced labour and other abuses *(11)*.

In sharp contrast, decriminalization of drug use and possession for personal use has been shown to facilitate the provision, access and uptake of health and harm reduction services. Czechia, the Netherlands, Portugal and Switzerland are among a handful of countries that have decriminalized drug use and possession for personal use and that have also financially invested in harm reduction. The number of new HIV diagnoses among people who inject drugs in these countries is low *(14)*.

Multiple UN and regional human rights mechanisms—including the UN Special Rapporteur on the right to the highest attainable standard of health, the UN Committee on Economic, Social and Cultural Rights, the African Commission on Human and Peoples' Rights, and the Office of the United Nations High Commissioner for Human Rights (OHCHR)—have found that criminalization of activities related to personal drug use can negatively affect a person's health and well-being, and they have recommended decriminalization of activities related to personal drug use *(15–19)*. In advance of the 2016 UN General Assembly Special Session on the World Drug Problem, four UN Special Rapporteurs joined the Chair of the Committee on the Rights of the Child to issue a statement describing the current international drug control regime as "excessively punitive" and calling for human rights obligations to be better integrated into the international drug control regime *(20)*.[1]

In 2017, 12 UN entities issued a joint statement on stigma and discrimination within health-care settings that called on countries to review and repeal punitive laws—including the criminalization of drug use and possession for personal use—that are proven to have negative health outcomes and that counter established public health evidence *(21)*.

The Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, adopted at the 2009 high-level segment of the Commission on Narcotic Drugs, set targets for countries to achieve by 2019, including a target to "eliminate or reduce significantly and measurably" the supply and demand for these drugs *(22)*. As this deadline approaches, data from the United Nations Office on Drugs and Crime (UNODC) show that the global war on drugs—and the punitive response to drug use—has failed to achieve these targets *(1)*. Recognition of this failure is growing, and more communities, cities and countries that are grappling with the realities of drug use are embracing harm reduction. Meanwhile, much of the world continues to wage a war on drugs and to turn its back on people who use drugs, slowing progress on the pledges they made at the UN General Assembly in 2016.

As a new chapter begins in the response to the world drug problem, UNAIDS calls on countries to end the divide on drug use. Stronger and more specifics commitments for a human rights-based, people-centred and public health approach to drug use are needed, and those commitments need to be rapidly transformed into national and local laws, policies, services and support that allow people who use drugs to live healthy and dignified lives.

1. The four Special Rapporteurs were Mr Juan E Méndez (Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment), Mr Christof Heyns (Special Rapporteur on extrajudicial, summary or arbitrary executions), Mr Seong-Phil Hong (Chair-Rapporteur of the UN Working Group on Arbitrary Detention), and Mr Dainius Pûras (Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health). They joined Benyam Dawit Mezmur, Chair of the UN Committee on the Rights of the Child.

RECOMMENDATIONS

The overarching purpose of drug control should be first and foremost to ensure the health, well-being and security of individuals, while also respecting their agency and human rights at all times. As UN Member States reflect on what has occurred in the 10 years since the 2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, UNAIDS reiterates its call for a public health and human rights approach to drug use, calling on countries to adopt the following recommendations.

Implement harm reduction services

Fully implement comprehensive harm reduction and HIV services—including needle–syringe programmes, opioid substitution therapy, naloxone and safe consumption rooms—on a scale that can be easily, voluntarily and confidentially accessed by all people who use drugs, including within prisons and other closed settings.

Ensure that all people who are drug dependent have access to noncoercive and evidence-informed drug dependence treatment that is consistent with international human rights standards. All forms of compulsory drug and HIV testing and compulsory drug treatment should be replaced with voluntary schemes. The use of compulsory detention centres for people who use drugs should cease, and existing centres should be closed.

Ensure widespread availability of naloxone, including injectable and noninjectable (nasal) forms, through community-based distribution of this life-saving public health measure. All people likely to witness an overdose—such as health workers, first responders, prison staff, enforcement officials, family members and peers—should have access to naloxone to enable timely and effective prevention of deaths from opioid overdose among people who use drugs.

Access to health-care services

Ensure that all people who use drugs have access to prevention, testing and life-saving treatment for HIV, tuberculosis, viral hepatitis and sexually transmitted infections (STIs).

Ensure adequate availability of and appropriate access to opioids for medical use to reduce pain and suffering.

Facilitate access for people who use drugs to HIV, sexual and reproductive health, and other health services through an integrated, people-centred approach that is gender-responsive and youth-friendly.

Ensure that universal health coverage systems are structured in a way that makes services accessible and acceptable to people who use drugs, including both integrated and stand-alone services, as needed.

Human rights, dignity and the rule of law

Protect and promote the human rights of people who use drugs by treating them with dignity, providing equal access to health and social services, and by decriminalizing drug use/consumption and the possession, purchase and cultivation of drugs for personal use.

Where drugs remain illegal, adapt and reform laws to ensure that people who use drugs have access to justice (including legal services) and do not face punitive or coercive sanctions for personal use, and that policing measures encourage people to access harm reduction and health services voluntarily. Ensure the principle of proportionality is applied for drug-related crimes, and put in place public health-based alternatives to incarceration, administrative penalties and other forms of corrective action.

Ending stigma and discrimination

Take action to eliminate the multiple intersecting forms of stigma and discrimination experienced by people who use drugs, including while accessing health, legal, education, employment and social protection services, or when interacting with law enforcement.

People-centred approach

Include, support, fund and empower communities and civil society organizations—including organizations and networks of people who use drugs—in all aspects of the design, implementation, and monitoring and evaluation of drug policies and programmes, as well as in the design and delivery of HIV, health and social protection services.

Ensure an enabling legal environment for civil society organizations of and for people who use drugs so they can operate without fear of intimidation, threat, harassment or reprisal.

Ensure use of social contracting modalities for engaging allied nongovernmental organizations for the delivery of community-led and community-based harm reduction services.

Investment

Undertake a rebalancing of investments in drug control to ensure sufficient funding for human rights programmes and health services, including the comprehensive package of harm reduction and HIV services, community-led responses and social enablers.

PEOPLE WHO USE DRUGS: A POPULATION UNDER ATTACK

1

Activists for people who use drugs and sex workers at their office in Kyiv, Ukraine.
Credit: Global Fund/Efrem Lukatsky.

PEOPLE WHO USE DRUGS: A POPULATION UNDER ATTACK

One in 18 adults use drugs

An estimated 275 million people worldwide—5.6% of the adult population—used drugs at least once in 2016 *(1)*. Cannabis is the most widely used recreational drug.[2] An estimated 19.4 million people used opioids, many of whom injected their drugs (Figure 3). Some non-opioid drugs—such as amphetamines, barbiturates, cocaine and methamphetamines—are sometimes consumed via injection.

Injecting drugs carries a high risk of HIV and viral hepatitis transmission if sterile injecting equipment is not easily accessible and injecting equipment is shared among users. In 2016, more than half of people who inject drugs were living with hepatitis C, and one in eight were living with HIV.

The prevalence of injecting drug use varies by region and country. For example, the eastern Europe and central Asia region was home to 21% of the world's people who inject drugs (aged 15–64 years) in 2016, despite having only 4% of the global population within that age range (Figure 4). Similarly, western and central Europe and North America had a greater share of people who inject drugs than their share of the global population *(2–4)*.

Almost half of all people who injected drugs worldwide in 2016 lived in just three countries: China, the Russian Federation and the United States of America. Although these three countries together account for just 27% of the global population (aged 15–64 years), they are home to 45% of the world's people who inject drugs—an estimated 4.8 million people *(1, 2)*.

Drug control efforts have little impact

The billions of dollars spent each year on efforts to reduce the supply of and demand for illicit drugs have not resulted in a reduction of the overall number of people who use drugs.

The United Nations Office on Drugs and Crime (UNODC) estimates suggest that the number of people who use drugs each year may have risen between 2006 and 2016, largely due to increased use of cannabis (Figure 5). However, this increase

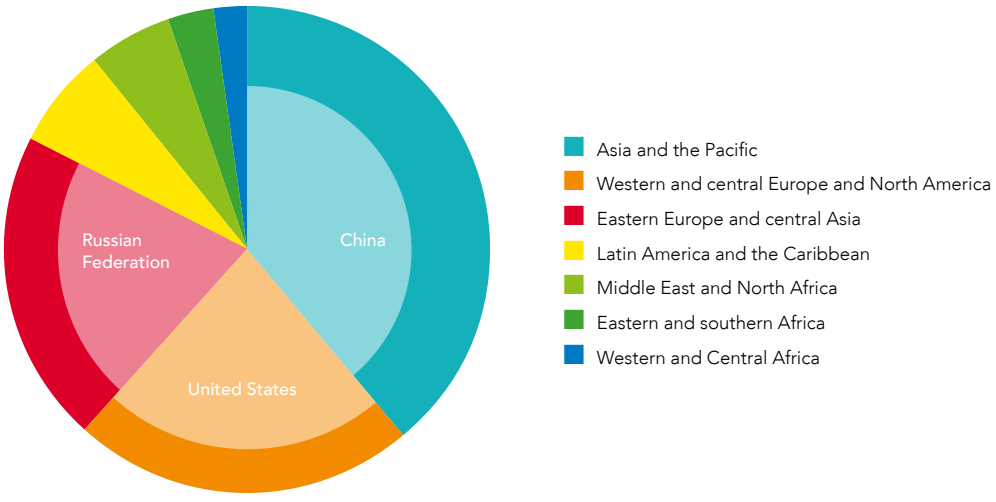
2. Not including alcohol and tobacco, which are not included in the estimate.

Figure 3. Population size of people who use drugs, global, 2016

Among the **275 million** people globally who used drugs at least once in 2016 **19.4 million** used opioids and **10.6 million** injected drugs, among whom **1.26 million** were living with HIV.

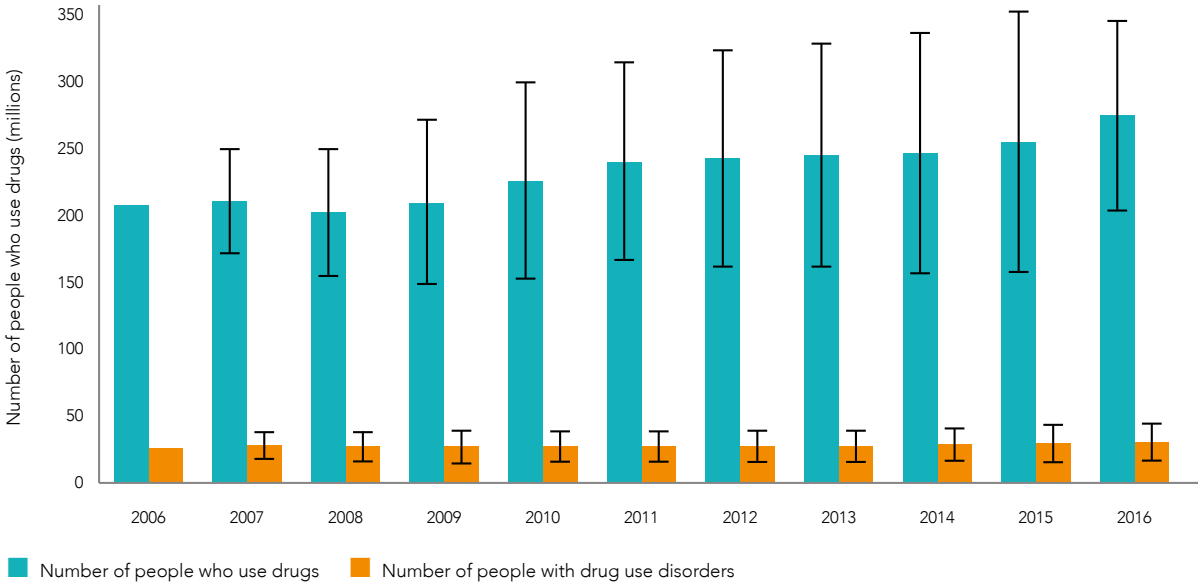
Source: World drug report 2018. Vienna: UNODC; 2019.

Figure 4. Number of people who inject drugs (aged 15–64 years), by region, 2016



Source: World drug report 2018. Vienna: UNODC; 2019.

Figure 5. Global trends in estimated number of people who use drugs (aged 15–64 years), 2006–2016



Source: World drug report 2018. Vienna: UNODC; 2019.

falls within the uncertainty bounds of the estimates and cannot be considered conclusive. Meanwhile, the number of people with drug use disorders has stayed roughly the same over the decade.[3]

UNODC and UNAIDS estimates suggest that the global number of people who inject drugs may be slowly declining, but this trend also lies within the uncertainty bounds of the estimates.

HIV is on the rise among people who inject drugs

The incidence of HIV infection among people who inject drugs appears to have risen over the past decade, from 1.2% [1.0–1.3%] in 2011 to 1.4% [1.2–1.5%] in 2017. This is in contrast to the overall trend worldwide, which shows a 25% decline in HIV incidence (all ages) between 2010 and 2017.[4] The decreasing size of the population of people who inject drugs and the increasing incidence of HIV within that population have contributed to an increase in the percentage of people who inject drugs who are living with HIV (up from 11.4% in 2011 to 12.5% in 2016) *(1, 5)*.

Hepatitis B and C and tuberculosis are also widespread

Hepatitis C virus is more resilient than HIV, and it is capable of surviving on drug preparation and injecting equipment for several days to weeks *(6)*. Hepatitis C virus is thus easier to transmit when injecting equipment is shared, and when people who inject drugs do not have access to needle–syringe programmes, hepatitis C infection is often more common than HIV infection. Globally, an estimated 51.9% of people who inject drugs had hepatitis C infection in 2016; among the 71 million people with hepatitis C globally in 2016, an estimated 8% were people who inject drugs *(7, 8)*.

An estimated 7% of people living with HIV who inject drugs have hepatitis B *(8)*. As more and more people living with HIV access antiretroviral therapy and thus live longer, coinfection with chronic hepatitis B is associated with accelerated progression of cirrhosis and higher rates of liver-related mortality *(8)*.

People who use drugs tend to have higher rates of tuberculosis and higher prevalence of latent tuberculosis infection than others *(9)*. This is in part due to high incarceration rates of people who use drugs: the risk of tuberculosis disease

3. UNODC defines people with drug use disorders as a subset of people who use drugs. People with drug use disorders need treatment, health and social care, and rehabilitation. Under the UNODC definition, the harmful use of substances and dependence are features of drug use disorders.
4. UNAIDS does not calculate estimates of HIV prevalence and incidence among noninjecting drug users. Data are not routinely collected for this population in the Global AIDS Monitoring system or the HIV estimates process.

in prisons is on average 23 times higher than the risk in the general population *(10)*. Among people living with HIV, those who inject drugs have a twofold to sixfold greater risk of developing tuberculosis than those who do not *(10)*.

Prevalence of multidrug resistant tuberculosis is also high among people living with HIV who use drugs *(9)*. In eastern Europe, access to treatment for multidrug resistant tuberculosis is low; as a result, mortality is high *(11, 12)*.

Women

Drug use is more common among men, with women accounting for just one in three people who use drugs and one in five people who inject drugs *(1)*. However, women who use drugs face special health risks.

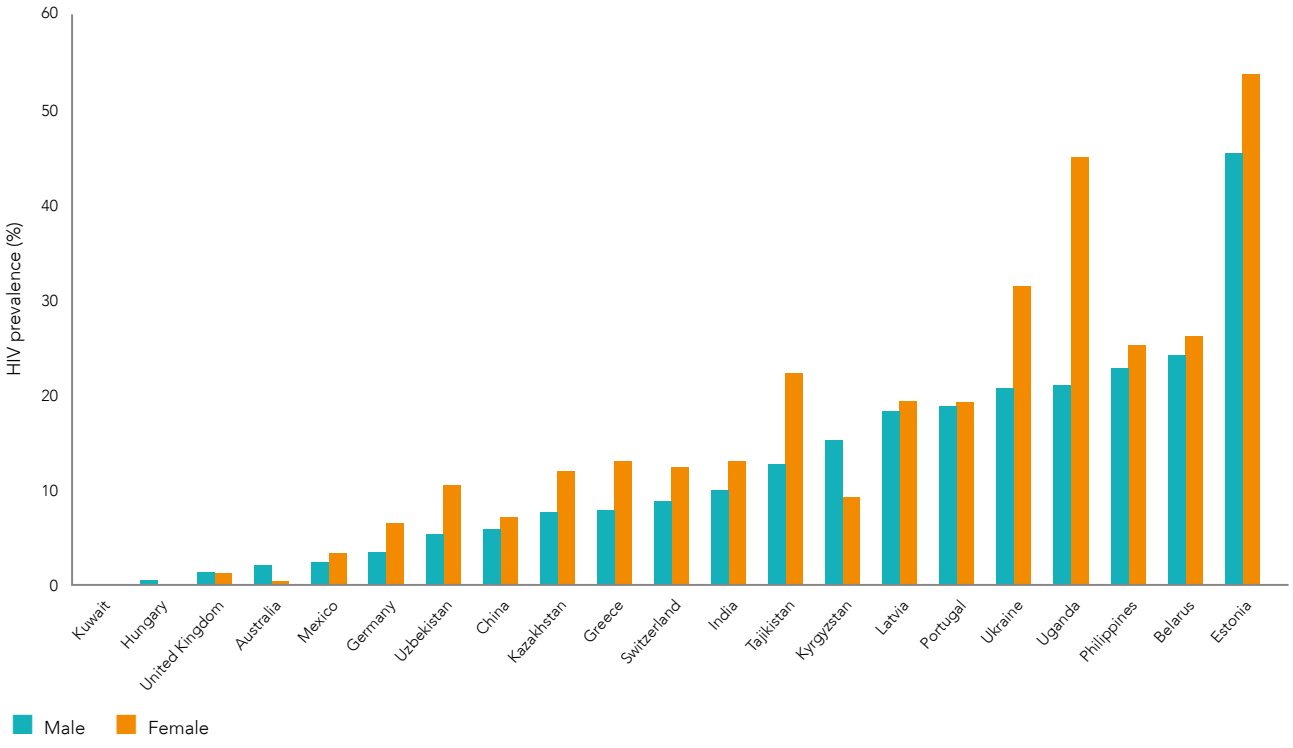
Although few countries report sex-disaggregated data to UNAIDS on people who inject drugs, the majority of publicly available data suggest that women who inject drugs have a greater vulnerability than men to HIV, hepatitis C and other blood-borne infections *(1)*. In 16 of the 21 countries that reported such data since 2013, women who inject drugs were more likely to be living with HIV than their male peers. In Germany, Uganda and Uzbekistan, HIV prevalence among women who inject drugs was almost twice as high as among their male peers (Figure 6).

Women also appear to be disproportionately affected by the criminalization of drugs, with higher rates of convictions and incarceration for drug-related offences than men. This has drawn the attention and condemnation of the UN Committee on the Elimination of Discrimination against Women (CEDAW) *(13, 14)*. CEDAW, along with the UN Working Group on Arbitrary Detention, has noted with concern the increasing number of women incarcerated for drug-related crimes, as well as the disproportionate rates of incarceration of poor and otherwise marginalized women. Those who are incarcerated often lack access to gender-sensitive health and harm reduction services *(15, 16)*.

Young people

Drug use among young people is generally more common than among older people, with substance use often peaking at 18 to 25 years *(1)*. Early life adversity is associated with an increased risk of substance use and dependence *(18)*. For example,

Figure 6. HIV prevalence among people who inject drugs by sex, last year available (2013–2017)



Source: UNAIDS Global AIDS Monitoring, 2013–2017.

CASE STUDY:
MEETING THE NEEDS OF WOMEN IN CONFLICT SETTINGS

Women who use drugs in conflict and emergency settings face complex challenges.

The armed conflict in eastern Ukraine, which started in 2014, has had a significant negative impact on people who use drugs. The nongovernmental organization Svitanok Club has conducted special surveys to understand the needs of this highly stigmatized population. Many women who use drugs migrated to other parts of Ukraine to avoid the conflict, but they returned when they were unable to find housing or employment, a challenge made worse by stigma and discrimination.

"They now live in extreme poverty, and simply have no money to pay for rent," says Svetlana Moroz of Svitanok Club. The women that Moroz has interviewed are often homeless. "They returned back to their homeland, but many still lost their homes." Many rely on other family members, leaving them vulnerable to intimate partner violence.

Moroz says that the women she studied—many of whom are survivors of abuse, including kidnappings and beatings—need specialized services. "They need psychological and psychotherapeutic support, and none of this is available. No one works with them on their traumatic experience of torture or other violence" *(17)*.

the risk of methamphetamine use is higher among young people who grow up in an unstable family environment, and many studies have observed high levels of substance use—including injecting drug use—among street children *(1)*.

Only a handful of countries have reported to UNAIDS age-disaggregated estimates of HIV prevalence among people who inject drugs. These data generally show that HIV prevalence is lower among younger people who inject drugs (under 25 years of age). Fewer years spent at higher risk of HIV infection (e.g., sharing injecting equipment) compared to older people who inject drugs is likely a factor in this difference.

Key populations

As well as people who inject drugs, key populations at high risk of HIV infection include sex workers, gay men and other men who have sex with men, transgender women and prisoners.

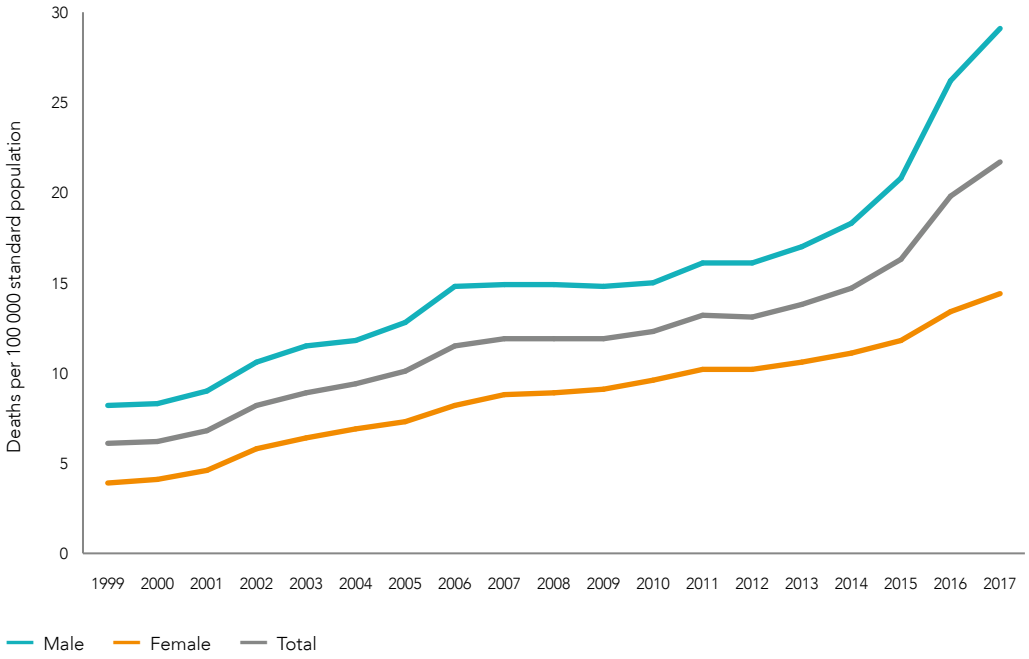
Many people within these key populations face multiple risks. Because same-sex sexual behaviour, sex work, and in some cases, diverse gender identities, are criminalized in many countries, lesbian, gay, bisexual, transgender and intersex (LGBTI) people and sex workers who use drugs all face additional vulnerability to police harassment and misconduct and to violence in detention *(19, 20)*. Stigma and discrimination, abuse or violence linked to sexual orientation, gender identity and sex work are also widely reported in health-care settings *(21)*. These multiple risks are likely to lead to higher HIV prevalence than among those who have only one type of risk *(22–26)*.

Sex workers who use drugs face multiple forms of violence, violations of privacy, and stigma and discrimination *(27)*. Chemsex—intentional sex under the influence of various psychoactive drugs—is on the rise among gay men and other men who have sex with men *(28, 29)*. The drugs used in chemsex are reported to reduce inhibitions and intensify pleasure, and chemsex may involve unprotected sexual activity with multiple partners. For these reasons, it is associated with increased rates of STIs, including HIV and hepatitis C *(30–32)*.

Violence

People who use drugs face an elevated risk of many forms of violence. For example, more than half of people who inject drugs surveyed in Pakistan reported that they had experienced physical violence in the previous 12 months *(33)*. In the Philippines, a national campaign to crack down on the drug trade has resulted in thousands of extrajudicial killings *(34, 35)*.

Figure 7. Age-adjusted drug overdose death rates, United States, 1999–2017



Notes: Deaths are classified using the International Classification of Diseases, 10th Revision. Drug poisoning (overdose) deaths are identified using underlying cause of death codes X40–X44, X60–X64, X85, and Y10–Y14.
Sources: NCHS, National Vital Statistics System, Mortality. Data Brief 329. Drug overdose deaths in the United States, 1999–2017. Data table for Figure 7. Age-adjusted drug overdose death rates: United States, 1999–2017 (https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf, accessed 25 February 2019).

Women who use drugs report particularly high rates of both gender-based violence and police abuse *(36)*. A 2016 study in Kyrgyzstan found that 60% of the women who use drugs surveyed in the study reported surviving physical or sexual violence in the past year *(36)*. Similarly, a study in Indonesia found that more than 50% of women who use drugs reported physical or sexual violence from their male partners in the previous year *(37)*. Sixty per cent of women in the same study who reported contact with law enforcement also reported verbal abuse by police, while 27% reported physical abuse and 5% reported sexual abuse. Violence perpetrated by police tends to be underreported due to the risk of retaliation.

Violence of all kinds exacerbates the existing risk of transmission of HIV and other blood-borne infections and STIs, and it can negatively affect the ability of women to negotiate safer sex and safer drug use *(38)*.

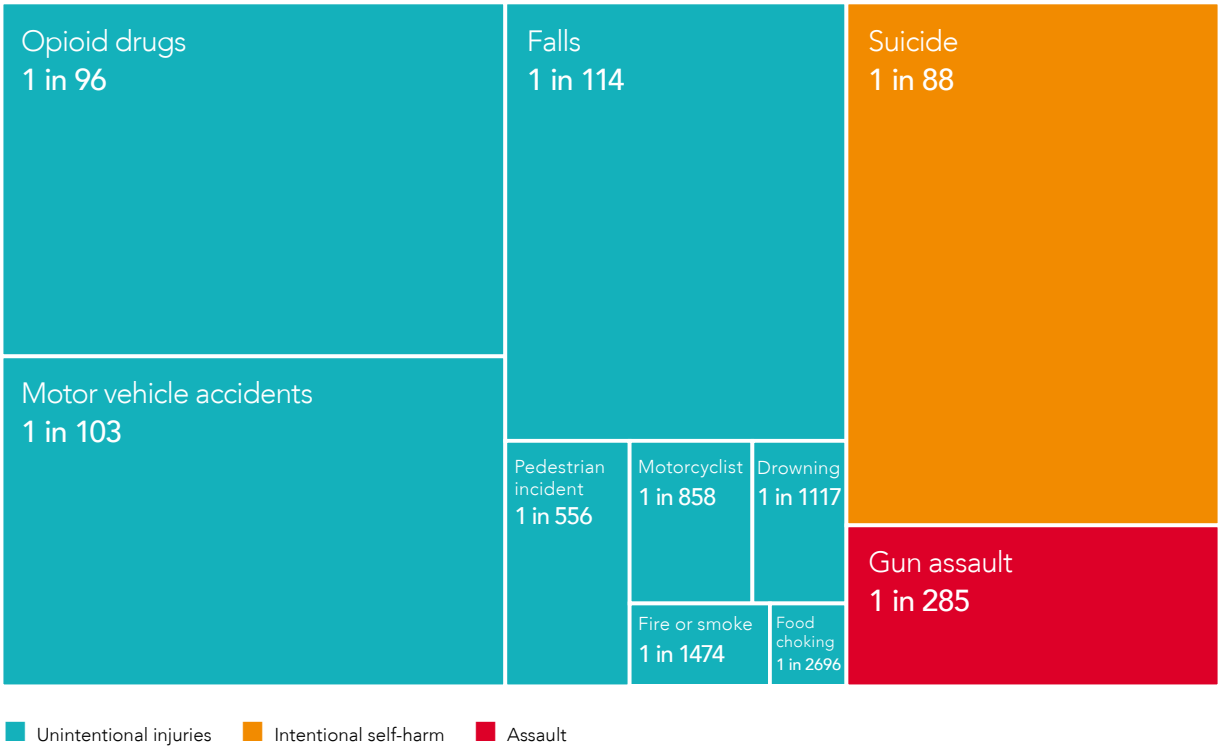
Mortality

Stigma and discrimination, violence and low access to health and harm reduction services together drive higher rates of mortality among people who use drugs. Globally, there were 450 000 deaths directly or indirectly related to drug use in 2015 *(1)*. The majority of these deaths were caused by overdose or were related to infections of HIV and hepatitis C. These were deaths that could have been prevented by harm reduction.

Opioid-related deaths are on the rise in many parts of the world. In the United States, deaths related to drug use increased sixfold from 1980 to 2014 *(39)*. Drug overdose deaths have recently skyrocketed in the United States, climbing by 16% annually since 2014, reaching 70 237 deaths in 2017 (Figure 7) *(40)*. In 2017, the lifetime odds of dying from an accidental opioid overdose in the United States exceeded for the first time the lifetime risk of dying in a motor vehicle crash (Figure 8).

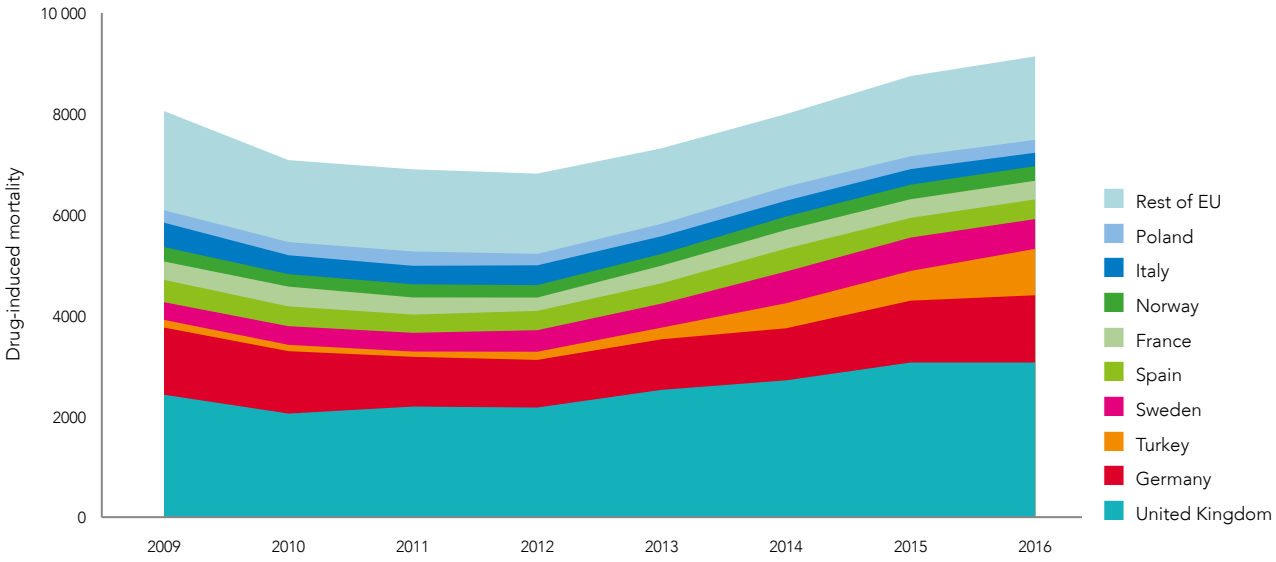
Canada is also experiencing an ongoing public health crisis of opioid overdoses. There were more than 9000 opioid-related deaths between January 2016 and June 2018, and 72% of accidental overdose deaths in 2017 involved either fentanyl or fentanyl analogues *(41)*. In the European Union, Norway and Turkey, opioid overdose deaths increased 34% in five years, from 6800 in 2012 to 9100 in 2016 (Figure 9) *(42)*.

Figure 8. Lifetime odds of dying due to injury, selected causes, United States, 2017



Source: National Center for Health Statistics. Mortality data for 2017 are compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Deaths are classified on the basis of the 10th Revision of *The international classification of diseases* (ICD-10), which became effective in 1999. See: https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/data-details/.

Figure 9. Drug-induced mortality, European Union member states, Norway and Turkey, 2009–2016



Source: Statistical bulletin 2018–overdose deaths. In: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [website]. Lisbon: EEMCDDA (http://www.emcdda.europa.eu/data/stats2018/drd).

HARM REDUCTION: LINKING HUMAN RIGHTS AND PUBLIC HEALTH

2

HARM REDUCTION: LINKING HUMAN RIGHTS AND PUBLIC HEALTH

The provision of harm reduction services has consistently reduced morbidity and mortality among people who use drugs.

The foundation of a rights-based public health approach to drug use, harm reduction is a set of principles and an evidence-informed package of services and policies that seeks to reduce the health, social and economic harms of drug use. Harm reduction is grounded in the recognition that not all persons who use drugs are able or willing to stop using drugs. The principles of harm reduction include trust, inclusivity, non-judgmental attitudes, flexibility to adapt to the needs of clients, and the active participation of the community of people who use drugs in planning, implementation and evaluation. Harm reduction services should also respect such fundamental rights as privacy, bodily integrity, dignity, due process and freedom from arbitrary detention.

"PEOPLE WHO INJECT DRUGS CAN BE FOUND IN ALL SEGMENTS OF THE SOCIETY. THEY ARE A PRIORITY TARGET OF SENEGAL'S NEW HIV/AIDS STRATEGY."

Safiatou Thiam, Executive Secretary of the Senegal National Council for the Fight against AIDS *(9)*

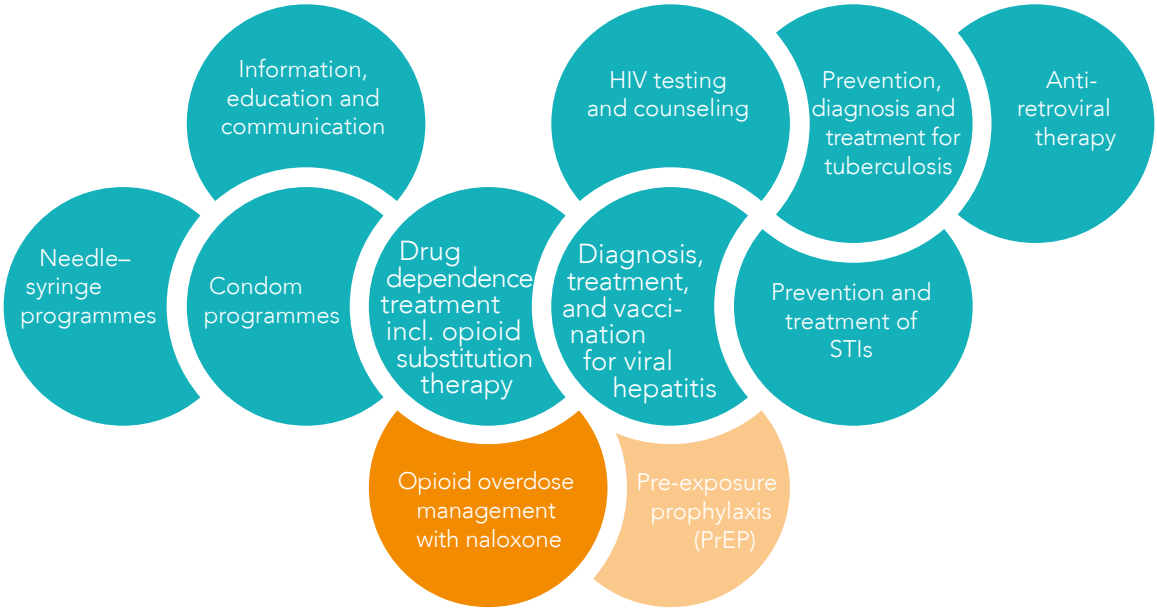
A comprehensive approach

The World Health Organization (WHO),United Nations Office on Drugs and Crime (UNODC) and UNAIDS recommend delivering a comprehensive set of harm reduction services to people who inject drugs, including the following:

- Needle–syringe programmes.
- Drug dependence treatment, including opioid substitution therapy.
- HIV testing and counselling.
- Antiretroviral therapy.
- Prevention and treatment of sexually transmitted infections (STIs).
- Condom programmes for people who inject drugs and their sexual partners.
- Targeted information, education and communication for people who inject drugs and their sexual partners.
- Diagnosis, treatment and vaccination for viral hepatitis.
- Prevention, diagnosis and treatment of tuberculosis *(1)*.

WHO has also recommended opioid overdose management with community distribution of naloxone for overdose prevention. Pre-exposure prophylaxis (PrEP) is not explicitly recommended for people who inject

Figure 10. A comprehensive approach to HIV and other harms associated with drug use



Source: Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: WHO, UNODC, UNAIDS; 2012; and Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016 update. Geneva: WHO; 2016.

drugs but should be available on demand to them *(2)*. Evidence also suggests that safe consumption sites offer many benefits *(3)*.

Needle–syringe programmes

Evidence

Needle–syringe programmes reduce the probability of transmission of HIV and other blood-borne diseases by lowering the rates of sharing of injecting equipment among people who inject drugs *(4, 5)*.

Coverage

To prevent HIV transmission, WHO recommends distributing 200 needles and syringes per person who injects drugs each year. In 2018, 86 countries had at least one operational needle–syringe programme *(6)*. However, of 68 countries that have reported programme data to UNAIDS since 2013, only 14 have distributed the recommended amount. Global programme coverage has remained largely static for the past seven years (see Annex 1).

Maximizing impact

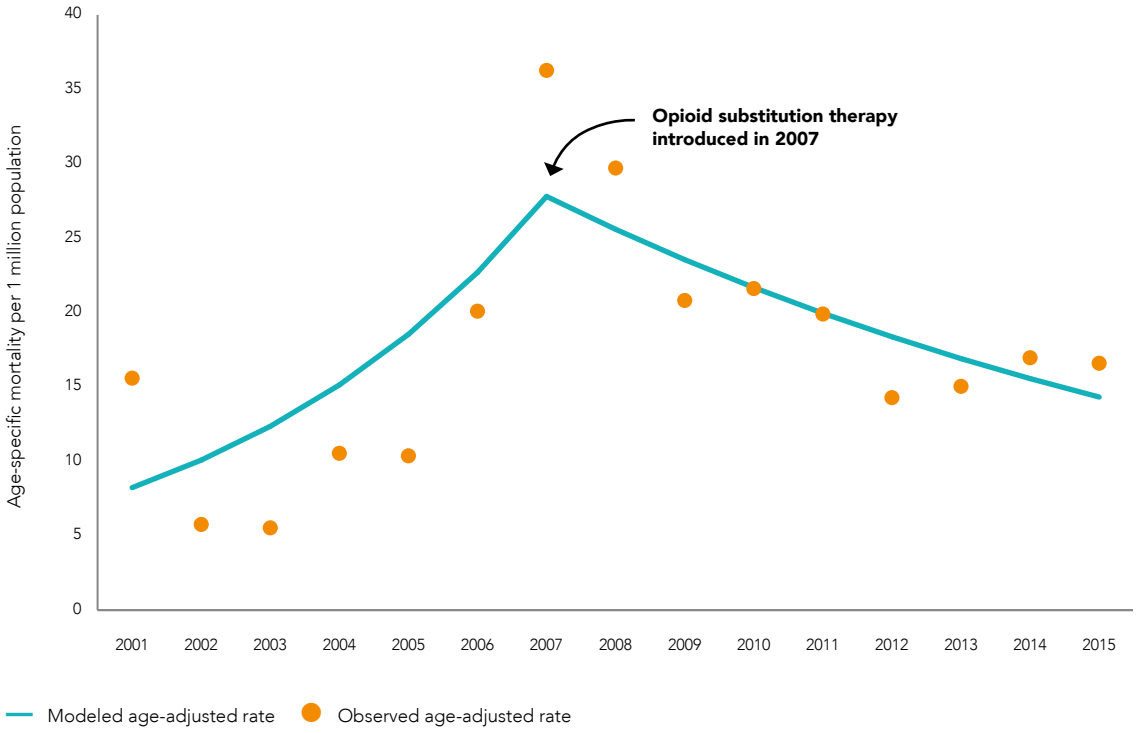
Well-designed needle–syringe programmes help clients access a range of related services, including drug dependence treatment, health care, and legal and social services. Programme managers should also understand the types of drugs that are injected, how they are injected and the type of injecting equipment that is preferred. Providing low dead-space syringes helps decrease the risk of transmission of HIV among people who inject drugs who continue to share injecting equipment *(7)*. However, if the injecting equipment provided does not fit local preferences, uptake may be low. WHO recommends offering a range of needle–syringe types to meet diverse needs *(1, 8)*.

Drug dependence treatment, including opioid substitution therapy

Evidence

Evidence-informed forms of drug dependence treatment, such as opioid substitution therapy using methadone or buprenorphine, curb the use of opioid drugs. They greatly reduce the risk of HIV and hepatitis C acquisition and reduce the risk of overdose *(10–13)*. Opioid substitution

Figure 11. Age-adjusted rates of overdose-related mortality, observed and modelled, Croatia, 2001–2015



Source: Handanagic S, Bozicevic I, Sekerija M, Rutherford GW, Begovac J. Overdose mortality rates in Croatia and factors associated with self-reported drug overdose among persons who inject drugs in three Croatian cities. Int J Drug Policy. 2019;64:95–102.

therapy has also been shown to substantially increase HIV treatment enrollment, treatment adherence and viral suppression among people living with HIV who inject drugs *(14)*.

Following the rapid escalation of overdose-related deaths in three cities in Croatia between 2001 and 2007, the introduction and scale-up of opioid substitution therapy coincided with a reduction in overdose mortality rates by an average of 8% annually between 2007 and 2015 (Figure 11) *(15)*.

There is also demand for effective treatment and support for dependence on noninjecting drugs and nonopioid drugs. Opioid substitution therapy may be effective for pharmaceutical opioid dependence *(16)*. Effective substitution treatment for dependence on stimulants, including cocaine, is in the pipeline; treatment trials using psychostimulants appear promising and deserve further study *(17)*.

Coverage

United Nations (UN) guidelines recommend 40% coverage of opioid substitution therapy *(10)*. While there is uncertainty in the estimates of opioid users in many countries, in most countries that have reported data to UNAIDS, the coverage of opioid substitution therapy among people who inject drugs is lower than desirable (see Annex 2). Harm Reduction International has documented the existence of opioid substitution therapy programmes in 86 countries *(6)*. A number of countries are scaling up these services: of the 23 countries that reported coverage data to UNAIDS in the last three years, 12 showed significant increases in the number of people enrolled. Afghanistan and Georgia reported large percentage increases, albeit from very low levels of coverage. Malaysia added more than 58 000 patients over a three-year period.

Maximizing impact

Only one in nine people who use drugs develop drug use disorders such as drug dependence *(83)*. Regardless, many people who use drugs are forced to enter compulsory drug dependence programmes,

PRISONS

Despite the universally-recognized principle that prisoners should enjoy the same standards of health care that are available in the community—and the explicit recognition by governments that health services in prisons should ensure continuity of treatment and care, including for drug dependence and HIV, tuberculosis and other infectious diseases—harm reduction coverage in prisons remains low *(23–26)*.

In 2017, only seven countries reported to UNAIDS that they had needle–syringe programmes in prisons, and just 18 reported prison programmes for opioid substitution therapy. The actual number may be higher: these did not include European Union member states, some of which also offer harm reduction in prisons *(27)*.

including in cases where treatment is not clinically indicated. This is a violation of their rights, and WHO and UNODC have stressed that drug dependence treatment should not be coerced *(18)*.

Additionally, relapse into drug use should not be grounds for expelling individuals from drug dependence treatment. Drug dependence is a chronic health condition that often requires long-term and continued treatment. Those affected may remain vulnerable to relapse for a lifetime. Patients who relapse need continued medical attention and support.

User fees for dispensing opioid substitution therapy may create barriers to accessing and maintaining therapy, and governments should consider sponsorship of fees, reducing fees or eliminating them altogether *(19–21)*. The Georgian Network of People who use Drugs has reported that eliminating user fees resulted in a sevenfold increase in drug dependence treatment coverage in just two years *(22)*.

HIV testing and treatment

Evidence

UN Member States have committed to achieving the 90–90–90 testing and treatment targets: to ensure by 2020 that 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment and 90% of people on treatment have suppressed viral loads. Antiretroviral therapy protects people living with HIV from AIDS-related illnesses and greatly lowers the risk that they will transmit the virus to others.

Coverage

Global progress towards these targets has been strong in recent years, but people who inject drugs and other key populations are often being left behind. Among the 13 countries that recently reported data to UNAIDS on treatment coverage among people living with HIV who inject drugs, eight stated that treatment coverage was lower among people who inject drugs than it was among the wider population of adults living with HIV (Figure 12).

Maximizing impact

It is essential to routinely offer voluntary, confidential HIV testing to people who use drugs, such as when individuals access needle–syringe services and drug dependence treatment.

Innovative approaches to reaching key populations have also been shown to deliver results, although some bring risks that must be carefully addressed. These innovative approaches include community-based testing, self-testing and diverse forms of index testing.

All HIV testing should be undertaken only with informed consent *(28)*.

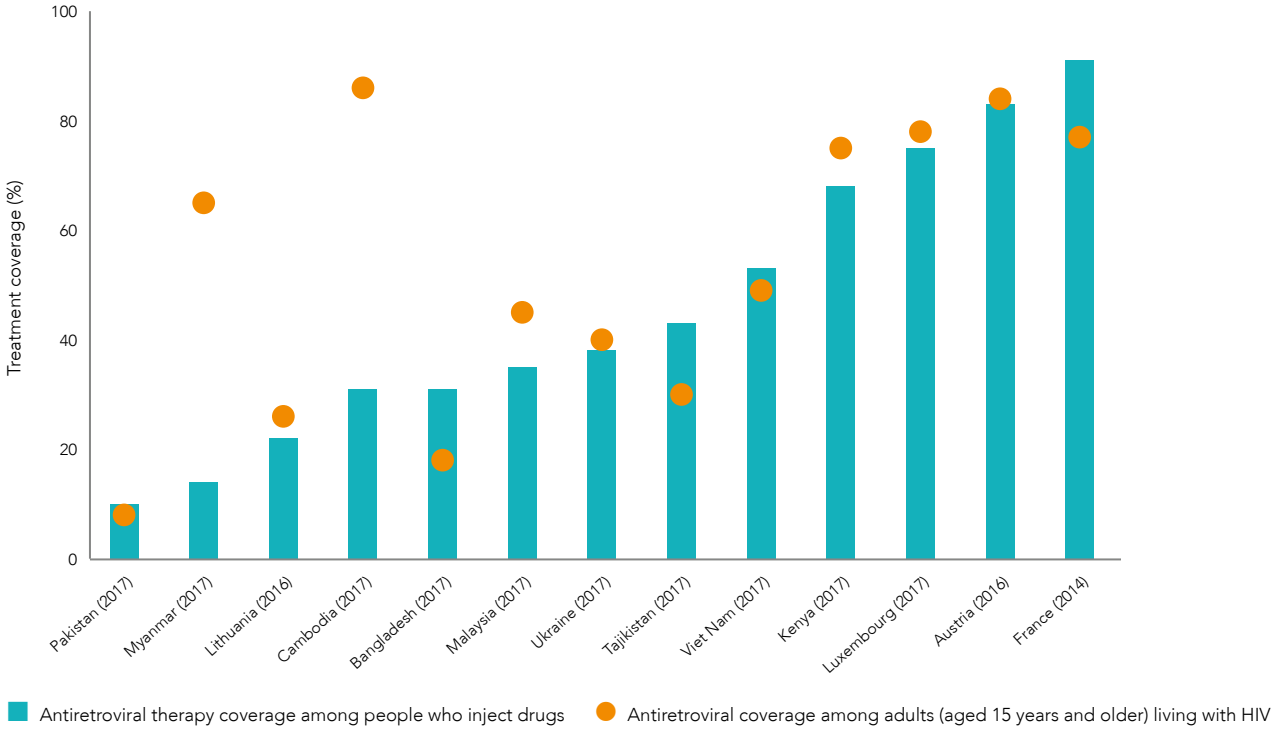
Community-based testing, linked to prevention, care and treatment, has the potential to reach greater number of people than clinic-based HIV testing and counselling—particularly those unlikely to go to a facility for testing, including people who inject drugs *(2, 29)*.

HIV self-testing is a form of testing where individuals gather their own specimens (oral fluid or blood) to perform an HIV test and interpret the results in private *(30, 31)*.

With index testing, a person with a confirmed diagnosis refers other untested individuals for HIV testing and counselling services. Two forms of index testing are assisted partner notification services and risk network tracing. Each comes with benefits and risks:

- Assisted partner notification is increasingly used among couples

Figure 12. Treatment coverage among all adults living with HIV and among people who inject drugs in particular, last year available (2014–2017)



Source: UNAIDS Global AIDS Monitoring, 2014–2017; and UNAIDS 2018 estimates.

in high-prevalence settings. It has proven highly effective at finding new cases *(32)*. Health-care workers should plan for and address the risk of intimate partner violence or social harm that may result following partner notification *(33)*.

- Risk network approaches, sometimes also referred to as "contact tracing," are widely used to reach key populations in concentrated epidemics. Using such an approach, health-care workers ask recently diagnosed individuals to refer others in their social networks for HIV testing. In Tajikistan and Ukraine, this approach has helped to efficiently find undiagnosed people living with HIV *(34, 35)*. Given the risks of discrimination, violence and arrest, HIV testing programmes working with key populations should consult with communities representing those populations before adopting risk network approaches to testing, and they should take measures to keep the personal data of individuals confidential.

WHO recommends that countries implement high impact interventions to prevent and respond to HIV drug resistance *(36)*. Integrating harm reduction and treatment can help to improve treatment adherence for people who use drugs, ensuring individuals are speedily referred for second-line treatment when needed. A recent systematic review found that providing opioid substitution therapy to people living with HIV who inject drugs significantly improved initiation of (and adherence to) antiretroviral therapy: this approach had a 45% better chance of patients achieving viral suppression *(37)*.

Combination prevention of HIV and STIs

Evidence

People who use drugs have multiple intersecting needs. Combined provision of condoms and lubricants, behavioural interventions, and sexual and reproductive health information and services (including contraception and STI testing and treatment) have been shown to lower the risk of sexual transmission of HIV and STIs. Staff of harm reduction services should be trained and supported to provide counselling for people

Opioid substitution therapy patient takes methadone at the District Heath Centre of South Tu Liem, Hanoi, Viet Nam. Credit: UNAIDS.

who use drugs on family planning and contraception, and they should understand the full range of the sexual and reproductive health needs and rights of both people who use drugs and their partners *(38)*. Tools such as the new United Nations Population Fund (UNFPA) and International Planned Parenthood Federation *Health, rights and well-being: a practical tool for HIV and sexual and reproductive health and rights programmes for young key populations in eastern Europe and central Asia* provides guidance on how to provide combined services in a manner that meets the needs of different populations *(39)*.

PrEP is one option that enables individuals to reduce their HIV risk by taking regular doses of antiretroviral medicines. WHO recommends that PrEP be offered as an additional prevention choice for all people at substantial risk of HIV infection *(2)*. However, the introduction of PrEP should not come at the expense of other proven low-cost interventions that reduce the health and social consequences of drug use.

Coverage

Condom programmes and behaviour change interventions designed for the general population are not adequately reaching people who use drugs. Among the 30 countries that have reported relevant data to UNAIDS since 2011, condom use at last sex among people who inject drugs was generally low, and fewer than one third did so in Hungary, Malaysia, Philippines and Serbia (see Annex 3).

There have been limited efforts to provide PrEP to people who use drugs. Community attitudes toward it vary *(40–42)*. Concerns about adherence, cost-effectiveness and the potential for coercive use—and insufficient engagement of communities in the development of pilot efforts—have all been raised by community groups and researchers *(41, 43–45)*. Civil society groups have also expressed concerns that the introduction of PrEP could be used as a substitute for other harm reduction strategies and that a strong focus on PrEP could indicate a re-medicalization of HIV *(44)*. Any decision about whether to include PrEP in harm reduction

CASE STUDY:
YOUNG WAVE

Young Wave is youth-led group in Lithuania that provides harm reduction services at music festivals and night clubs. Young Wave volunteers join public gatherings of young people to share information about safe drug use, condoms, water (to prevent dehydration and overheating), straws for snorting drugs (to prevent transmission of viral hepatitis) and drug checking. Young Wave also provides psychedelic peer support (PsyHelp), an approach that aims to transform challenging psychedelic experiences into learning opportunities, and to reduce hospitalizations and other harms. The group also engages in policy advocacy, and it provides harm reduction training to police *(88)*.

programmes should be made only with the active consultation and engagement of the community of people who use drugs, and it should take their preferences into account. Some national programmes have developed specific guidance to assess the suitability of PrEP for people who inject drugs *(46, 47)*.

Prevention and management of viral hepatitis and tuberculosis

Evidence

People who use drugs face increased risk of tuberculosis infection, including a high risk of multidrug-resistant tuberculosis. WHO recommends a package of collaborative tuberculosis/HIV activities. Key services include tuberculosis preventive treatment, such as isoniazid preventive therapy, regular screening for early diagnosis of tuberculosis, and timely initiation of anti-tuberculosis therapy and antiretroviral therapy for people living with HIV who use drugs *(2, 48)*.

People who inject drugs face additional vulnerability to hepatitis B and C *(49, 50)*. Direct-acting antivirals are recommended for the treatment of all people with chronic hepatitis C infection *(51)*. They have cure rates of around 95% and are far less toxic and better tolerated than interferon-based treatments (which are no longer recommended); they also can be provided to all persons with chronic hepatitis C infection. Several new direct-acting antiviral medicines have been approved by at one least stringent regulatory authority since 2013 *(52)*.

Prevention strategies for hepatitis B infection among people who use drugs focus on vaccination and ensuring that sterile injection equipment is available. Hepatitis B infection is a chronic disease, and most people require ongoing antiviral treatment *(53)*.

Coverage

Direct-acting antiviral therapies are not yet widely accessible. In many countries, the high price of direct-acting antiviral therapies or collateral fees charged for diagnosis makes access to them challenging for people who use drugs, and governments are reluctant to prioritize investment in the treatment *(54, 55)*. Despite this, recent price reduction strategies, including the use of generics, have made direct-acting antivirals more affordable in a wide range of countries.

In some countries, people who use drugs are often refused hepatitis C treatment, whether pre-emptively or through bureaucratic requirements *(56)*. In some cases, individual providers and hospitals deny direct-acting antiviral treatment to people who use drugs, in contravention of national policies *(57, 58)*. This is despite evidence showing that treatment outcomes for people who inject drugs, including those actively using drugs, have been as good as with other patients *(59)*.

Maximizing impact

Newly-published guidance on implementing comprehensive HIV and hepatitis C programmes for people who inject drugs recommends a set of practical approaches that are grounded in community empowerment *(60)*. Wherever possible, health services for people who use drugs should be integrated. In countries with high tuberculosis incidence, harm reduction programmes should consider including the provision of 12-week tuberculosis prevention for people who use drugs when tuberculosis screening is negative. According to WHO, countries with low tuberculosis incidence may consider systematic testing for (and treatment

"LIKE FEMINISM, HARM REDUCTION IS A PHILOSOPHY THAT ENCOURAGES US TO DO AWAY WITH THE FALSE DISTINCTION BETWEEN 'GOOD' AND 'BAD' WOMEN."

Fenya Fischler, Association for Women's Rights in Development (AWID) *(80)*

of) latent tuberculosis infection for all people who use drugs *(61)*.

Overdose management with naloxone

Evidence

Naloxone is an effective treatment for opioid drug overdoses. Improving access to naloxone through take-home programmes saves lives *(62)*. Studies of community opioid overdose prevention show survival rates of 83–100% post-naloxone treatment *(6)*. WHO guidelines recommend that all people likely to witness an overdose—including people who use drugs, their families and peers—should have access to naloxone *(63)*. There are several ways to administer naloxone, including through intramuscular injection or nasal spray.

Coverage

The availability of take-home naloxone is low. Among 108 countries that reported to UNAIDS in 2017, 19 stated that they had naloxone available through community distribution. Civil society verified this in 53% of the reporting countries. Harm Reduction International's most recent review of harm reduction data found that naloxone peer distribution was operational in 12 countries (see Annex 4 for details). However, not all countries that provide injectable naloxone also provide syringes within easy-to-use kits, and only five countries provide naloxone to prisoners upon release, despite the heightened risk of overdose that these individuals face *(6)*.

The cost of the medication is also an issue. In the States of America, prices for naloxone have risen by more than 600% since 2015 *(64)*. In Thailand, a project that facilitates access to naloxone in 19 Thai provinces is threatened due to diminishing national funds *(6)*.

Several cities and countries have recently scaled up naloxone distribution alongside other harm reduction measures in response to rising overdose deaths *(65–67)*. For example, the city of Dayton, Ohio, was once considered the epicentre of opioid-related fatalities in the United States. The establishment of a new compassionate approach to drug use in Dayton and the surrounding county—including the launch of harm reduction services that included needle–syringe and naloxone distribution—was followed by a 65% decline in overdose deaths in just one year, from 378 in the first half of 2017 to 132 in the first half of 2018 *(68)*.

Maximizing impact

Making naloxone available through peer distribution schemes and over the counter without a prescription improves uptake *(6)*. However, legal and regulatory restrictions often block distribution to nonmedical personnel. Efforts to improve community distribution of intranasal sprays and kits with autoinjector intramuscular delivery systems include: (a) provision of education and training; (b) reduction of prescribing barriers to access; and (c) reduction of legal recrimination fears as barriers to use (69). Estonia and Scotland are among the jurisdictions providing easy-to-use injectable naloxone kits *(66, 70)*.

Supervised drug consumption sites

Evidence

While there has been insufficient research to date, evidence suggests that supervised drug consumption sites, also known as "drug consumption rooms," reduce the risk of disease transmission and other harms, and that individuals who

A community health worker picks up a five-day supply of methadone for clients, who can then access their daily dose at Rumah Singgah PEKA, a community-based harm reduction programme in Indonesia. PEKA, which aims to empower people who use drugs to re-establish control of their lives, has more flexible hours than public health facilities. Credit: UNAIDS/UNODC/Edward Wray.

visit supervised drug consumption sites adopt safer injection practices when outside of the facilities *(71)*. The International Narcotics Control Board (INCB) has noted that current research demonstrates that safe injecting facilities succeeded in attracting hard-to-reach populations, promoting safer injections and reducing overdose risk, and it has called for further research *(72)*.

Coverage

Supervised drug consumption sites now operate in at least 11 countries around the world: Australia, Belgium, Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Spain and Switzerland. Three countries are expected to open supervised drug consumption sites in 2019, namely Ireland, Mexico and Portugal *(6)*.

Needs of specific groups

There is a growing need for harm reduction services designed to meet the specific needs of various subpopulations of people who use drugs, including women, young people, people of diverse sexual orientations and gender identities, sex workers, people who use new psychoactive substances and people who need mental health care.

Women

Women who use drugs face particular challenges in accessing harm reduction services *(73)*. Higher levels of stigma and discrimination and harmful gender norms translate to lower control over injecting and more frequently being "second on the needle" during the sharing of injecting equipment *(74)*. However, few harm reduction programmes tailor their services to meet the needs of women; sex and gender-based discrimination may make them unwelcoming *(75, 76)*. Many such programmes do not provide childcare facilities, sexual and reproductive health services, services to tackle gender-based violence, adequate opening hours or staff trained to respond to gender-specific needs *(76, 77)*.

UNODC recommends gender-responsive interventions that incorporate the needs of women into their design and implementation, including consideration of their location, staffing, programme development, approach and content *(78)*. Addressing the sexual and reproductive health needs of women who use drugs is a critical aspect of comprehensive and integrated

The Narcotics Prison Cipinang in East Jakarta, Indonesia, is one of 11 model prisons implementing a comprehensive HIV programme where antiretroviral treatment and methadone services are provided. Credit: UNAIDS.

"IT HAS BEEN A CHALLENGE TO ADVOCATE FOR THE IMPLEMENTATION OF HARM REDUCTION-ORIENTED INTERVENTIONS IN LATIN AMERICA AND THE CARIBBEAN, DESPITE REPEATED EVIDENCE SHOWING ELEVATED HIV PREVALENCE RATES AMONG CERTAIN SUBGROUPS OF STIMULANT USERS, INCLUDING PEOPLE WHO USE STIMULANTS AND SELL SEX OR [THOSE WHO] ENGAGE IN STIMULANT USE AND CONCURRENT UNPROTECTED INSERTIVE ANAL OR VAGINAL SEX."

Marcus Day, Caribbean Drug and Alcohol Research Institute *(88)*

care. In 2018, WHO and UNFPA led a renewed call to action to strengthen delivery of linked sexual and reproductive health rights and HIV programmes and services as an essential focus for ensuring universal coverage *(79)*.

Young people

Young people who use drugs require special outreach by trusted intermediaries. Young people who inject drugs are particularly vulnerable to HIV infection and other blood-borne viruses, violence and human rights abuses. Guidance is available for working with this key population *(81)*.

One emerging approach is to reach young people at music festivals. In 2018, Australia's New South Wales Ministry of Health published

CASE STUDY:
REACHING WOMEN WHO INJECT DRUGS IN THE ISLAMIC REPUBLIC OF IRAN

Iran is home to 200 000 people who inject drugs, 9.3% of whom are living with HIV. Women who use drugs are extremely marginalized and stigmatized, rejected by their families, and likely to live in extreme poverty without social support.

Iran is one of the two countries in the Middle East and North Africa region to have adopted a national strategy that supports harm reduction and provides needle–syringe programmes and opioid substitution therapy *(6)*. In 2016, 207 drop-in centres, 331 outreach teams and 68 shelters provided harm reduction services to more than 125 000 people who use drugs *(95)*.

Iran offers several women-only drop-in harm reduction centres. The Rebirth Charity Organization began offering services to women who use drugs in 2002. A special residential facility houses pregnant women, and it was recently expanded to admit women with children under the age of six years. Women receive reproductive health services, HIV testing and linkages to treatment, drug treatment (including opioid substitution therapy), information about self-care and nutrition, training in parenting skills and more. The centre also houses a kindergarten.

The facility is funded by the state, with individual benefactors providing in-kind contributions of food and clothing *(95)*.

guidelines on harm reduction at festivals. Their recommended interventions include testing for STIs, provision of water and shade (to prevent dehydration and overheating), and the early involvement of peer-based harm reduction programmes in event planning *(82)*.

Users of new psychoactive substances

Hundreds of forms of new psychoactive substances are now circulating within global drug markets *(83, 84)*. Drug control operations that aim to eliminate traditional psychoactive drugs have created a growing demand for synthetic substances that are not controlled by existing international conventions *(77)*. People who inject these substances also face the additional risk of blood-borne infections *(85)*. To address these risks, European harm reduction programmes have introduced drug checking, also known as "pill testing" or "reagent testing," at clubs and festivals *(86)*.

Lesbian, gay, bisexual, transgender and intersex people and sex workers

When it comes to harm reduction services, the specific needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) people and sex workers who use drugs are often overlooked in policies and programmes. Harm reduction programmes should take into account the individual, social and societal effects of drug use—and the specific risks and vulnerabilities faced by LGBTI people—in order to tailor evidence-informed interventions to their specific needs *(89)*.

The International Network of People Who Use Drugs (INPUD) and the Global Network of Sex Work Projects (NSWP) note that harm reduction services are especially effective when education, empowerment, outreach and distribution are peer-led *(90)*. A community-led harm reduction approach to chemsex in Australia led to increased service uptake *(91)*. PrEP on demand may be a suitable approach for people who use drugs and practice chemsex when it is provided as part of a comprehensive prevention and harm reduction programme that is grounded in strong community engagement *(92)*.

Mental health care

The multifaceted stigma and discrimination faced by people who use drugs has been linked to anxiety, depression, poor self-esteem and poor adherence to antiretroviral therapy. Mental health care (such as counselling) and psychosocial support programmes (such as support groups) can reduce self-stigma associated with HIV status, substance use and/or

"FUNDING FOR HARM REDUCTION IS IN CRISIS GLOBALLY, ESPECIALLY FOR SERVICES DESIGNED TO MEET THE NEEDS OF PEOPLE WHO DON'T INJECT DRUGS. IF THE UN WERE TO DEVELOP ROBUST TECHNICAL GUIDANCE ON HARM REDUCTION FOR NON-INJECTING POPULATIONS, IT WOULD HELP STRENGTHEN THE CALL ON DOMESTIC GOVERNMENTS AND DONORS TO INVEST IN HOLISTIC HEALTH AND SOCIAL SERVICES FOR PEOPLE WHO USE DRUGS."

Olga Szubert, Harm Reduction International *(94)*

mental health conditions; it also can promote adherence to treatment *(93)*. More broadly, countries should act to remove the broader social stigma and discrimination that surrounds drug use.

Low investment

Overall financial investment in harm reduction services remains low. In 2018, Harm Reduction International declared a "crisis" in harm reduction funding in low- and middle-income countries, stating that only 13% of the funding required annually for an effective HIV response for people who inject drugs was available *(6)*. A comparison of UNAIDS Fast-Track resource needs estimates and expenditure data that were reported by 17 low- and middle-income countries in 2017 and 2018 shows that spending on HIV programmes that focused on people who inject drugs was insufficient in all but three countries: Kenya, Nigeria and South Africa *(96, 97)*. In many cases, expenditures were less than half of the resources needed for that year (Figure 13).

Domestic funding appears to be particularly low. Among the 31 countries that have reported expenditure data to UNAIDS since 2014, 71% of the spending was covered by international donors.[5] Donor expenditure data collected by UNAIDS show US$ 31.3 million (January to December 2016) and US$ 12.5 million (October 2016 to September 2017) in spending on HIV programmes focused on people who inject drugs in low- and middle-income countries by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR), respectively. According to Harm Reduction International, support for harm reduction in low- and middle-income countries from the Global Fund was 18% lower in 2016 than in 2011 *(6)*.

These figures only include expenditures on service provision. They do not include expenditures for social enablers, such as advocacy and work on law reform, training and sensitization of law enforcement personnel, programmes to reduce stigma and discrimination, violence prevention, legal empowerment and rights education of communities, programmes to reduce harmful gender norms, and empowerment of community and peer support networks. Investment in social enablers is essential to fulfilling the rights of people who use drugs.

In the 2016 Political Declaration on Ending AIDS, countries committed to ensuring that at least 6% of HIV resources are allocated for social enablers. Despite this, political and administrative barriers to financing social enablers persist, impeding access to funding for civil society groups.

5. Afghanistan, Algeria, Armenia, Azerbaijan, Bangladesh, Belarus, Benin, Dominican Republic, Kazakhstan, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Madagascar, Malawi, Malaysia, Mexico, Mozambique, Myanmar, Namibia, Nepal, Nigeria, Republic of Moldova, Romania, Russian Federation, Samoa, Senegal, Seychelles, South Africa, Tajikistan and Ukraine.

Figure 13. Expenditures on HIV programmes focused on people who inject drugs, 17 countries, 2016–2017, and resource needs for the reporting year and 2020

Sources: UNAIDS HIV Financial dashboard; UNAIDS Global AIDS Response Progress Reporting and Global AIDS Monitoring reports 2015–2018; Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD et al. What is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track Approach. PLoS ONE. 2016;11(5):e0154893.

"BELARUS IS EXPANDING ITS FUNDING BOTH FOR HIV TREATMENT AND FOR HIV PREVENTION AMONG PEOPLE WHO INJECT DRUGS. BELARUS IS ONE OF REGIONAL LEADERS IN USING SOCIAL CONTRACT MECHANISMS TO SUPPORT HARM REDUCTION SERVICE PROVISION THROUGH NONGOVERNMENTAL ORGANIZATIONS."

Dmitry Pinevich, First Deputy Minister of Health, Belarus *(98)*

Universal health coverage and the problem of discrimination

As part of the Sustainable Development Goals, all countries have committed to achieving universal health coverage as a core driver of development *(99)*. However, expanding health coverage alone has not been an effective solution to the problem of expanding access to health services for people who inject drugs. Harm reduction services and treatment of drug dependence may be excluded from health insurance coverage, and numerous quantitative and qualitative studies have found that people who use drugs experience stigma and discrimination in the health sector, which deters them from seeking health services *(59, 100–103)*.

The global campaign for primary health care and universal health coverage should give special attention to the needs of people who use drugs, as their extreme marginalization makes their experiences a litmus test for the success of these broader efforts. To find practical solutions to these challenges during the roll-out of universal health coverage schemes, states should ensure that civil society groups led by people who inject drugs participate meaningfully in health governance. This includes participating in resource allocation decisions and at all stages of policy-making, implementation and evaluation. States should also take steps to address the persistent human rights barriers to health services that are faced by people who use drugs by investing in community-led advocacy and service provision and access to justice. service provision, and by establishing systems for social contracting. These issues are discussed further in the next two sections.

Sino, an outreach worker from Trust Point Centre, Khorog, Tajikistan, distributes sterile injecting equipment and information leaflets in Khorog bazaar. Credit: Global Fund/John Rae.

OVERCOMING THE HUMAN RIGHTS BARRIERS TO HEALTH, DIGNITY AND WELL-BEING

3

OVERCOMING THE HUMAN RIGHTS BARRIERS TO HEALTH, DIGNITY AND WELL-BEING

The stated purpose of international drug policy is to safeguard the health, well-being and security of people and society. The dominant approach to illicit drugs, however, continues to be one of criminalization and incarceration. This is despite countries agreeing again and again, including within the Commission on Narcotic Drugs and at the 2016 United Nations (UN) General Assembly Special Session, , that drug policy must be informed by human rights and committing to adopt a more balanced, integrated, evidence-informed and human rights-based approach *(1–3)*.

Criminalization

Criminalization of activities related to personal drug use has been shown to increase stigma and discrimination, decrease the availability and accessibility of HIV and harm reduction services, and drive people who use drugs away from the services that are available *(4, 5)*.

"AS COMMUNITIES OF PEOPLE WHO USE DRUGS, WE BELIEVE THAT THE ONLY WAY FOR RIGHTS AND DIGNITY TO BE RESTORED IS FOR DRUG USE AND PEOPLE WHO USE DRUGS TO BE DECRIMINALIZED."

Judy Chang, International Network of People Who Use Drugs (INPUD) *(26)*

Such criminalization also has been linked to police abuse, including coerced confessions, torture and extortion of bribes *(6, 7)*. It has disastrous effects on the families of those detained, such as removing children from the care of their parents *(5, 7, 8)*.

Decriminalization entails countries removing criminal penalties on the use, possession and sometimes cultivation of small quantities of drugs for personal use. In some models of decriminalization, these activities remain subject to fines or other administrative penalties. In other frameworks, the state removes all penalties for use or possession within authorized parameters. Legalization entails the legal cultivation and sale of controlled substances, within certain parameters. In Portugal, for example, decriminalization of activities related to drug use—along with the scale-up of harm reduction and related services—triggered a sharp decline in the incidence of HIV infection related to injecting drug use and a decline in the numbers of those incarcerated *(9)*.

A growing number of public health and professional bodies have called for decriminalization *(11)*. UN human rights treaty bodies, human rights special procedures, UN agencies, regional human rights bodies, and the Global Commission on HIV and the Law have additionally found that criminalization of drug use and

The Myanmar Anti-Narcotics Association (MANA) works to reduce HIV among people who inject drugs by raising awareness of behavioural risks and by supplying sterile injecting equipment. MANA also provides basic medical care, testing and counselling, and support for people who inject drugs to transition to opioid substitution therapy. Credit: Global Fund/John Rae.

"BASICALLY THE POLICE SEEM TO BE A MAIN BARRIER FOR HARM REDUCTION POLICY IMPLEMENTATION.HOWEVER, IF THE POLICE WORK CLOSELY WITH CIVIL SOCIETY, IT WILL HELP A LOT IN TERMS OF HIV PREVENTION AND HARM REDUCTION SERVICE PROVISION."

Krisanaphong Poothakool, Police Lieutenant Colonel, Royal Police Cadet Academy, Thailand *(36)*

possession for personal use amounts to a breach of human rights and have called for their decriminalization *(12–17)*.

For decriminalization of activities related to personal drug use to work well in practice, the alternatives to incarceration must be appropriate, proportionate and voluntary. Compulsory detention and treatment is not an acceptable alternative. High fines can place a heavy financial burden on people who use drugs and their families, sometimes also resulting in imprisonment *(18, 19)*.

In 2018, the International Drug Policy Consortium reported that 26 countries now take a decriminalization approach to activities related to personal drug use *(20)*. A few countries, such as Canada and Uruguay, have legalized the personal possession of cannabis entirely *(21)*.

Despite the growing global consensus on decriminalization of activities related to personal drug use, most countries continue to criminalize activities related to personal drug use or to impose coercive and punitive responses. Some countries have increased penalties and intensified policing efforts in recent years. In January 2017, for example, Lithuania criminalized the possession of any amount of drugs, resulting in hundreds of arrests for possession of small amounts *(18)*. In the Philippines, a national campaign to crack down on the drug trade has resulted in thousands of extrajudicial killings *(22, 23)*. According to Amnesty International, one result of the campaign has been that people who inject drugs in the Philippines are now afraid to seek out HIV testing and treatment *(24)*. In 2018, 38 members of the UN Human Rights Council issued a statement urging the Philippines to end extrajudicial killings and to allow an independent investigation *(25)*.

Disproportionate sentencing, including the death penalty

The UN Human Rights Committee has called on countries that have the death penalty to restrict its use to the most serious crimes and only in exceptional circumstances. To do otherwise breaches the right to life under the International Covenant on Civil and Political Rights. Such exceptional circumstances, according to the Committee, do not include drug crimes *(27)*. The International Narcotics Control Board (INCB) also has encouraged states to abolish the death penalty for drug crimes *(28)*.

In 2018, 35 countries or territories retained the death penalty for drug offenses. Since 2015, there has been a steady decline in known executions of persons who have been convicted of a drug offence *(29)*. Harm Reduction International documented fewer than 100 such executions in 2018, the lowest since it started collecting data in 2008 *(29)*.[6] More than 7000 people were on death row for drug offences globally in 2018 *(29)*.

Some countries have begun to relax drug-related sentencing. Malaysia, for example, has signalled that it will remove the death penalty for drug-related offences *(30)*. Prior to 2017, the Islamic Republic of Iran had one of the highest rates of executions for drug-related offences, but it revised the legal threshold for drug-related death sentences in 2017, leading to

6. Four countries—China, the Islamic Republic of Iran, Saudi Arabia and Singapore—were known to have executed people for drug offences in 2018.

"WHATEVER THEIR OWN PERSONAL BELIEFS, POLICE SHOULD NOT PUT THEIR MORAL JUDGEMENT OVER PUBLIC HEALTH; PEOPLE WHO USE DRUGS ARE HUMAN BEINGS WITH HEALTH PROBLEMS, AND THE PROPER APPROACH FOR POLICE IS HARM REDUCTION."

Assistant Commissioner of Police, Jones Blantari, Ghana Police *(37)*

a sharp decrease in the number of drug-related executions (from 221 in 2017 to 23 cases in 2018) *(29)*.

Law enforcement and access to harm reduction

UN human rights mechanisms, including the Human Rights Council, have affirmed that access to harm reduction services is a human right *(31)*.[7] Despite overwhelming evidence of the effectiveness of harm reduction services, laws and practices in a number of countries restrict these services *(32)*. Even where harm reduction services are not legally restricted, some actions by law enforcement agents can impede access to them.

Confiscating injecting equipment, even in places where needle–syringes are not legally restricted, discourages individuals from carrying and using them. People who have experienced random drug testing are more likely to avoid health care, and arresting people who inject drugs when they visit harm reduction sites has the predictable effect of discouraging use of such services *(6)*. Requiring individuals to register for harm reduction services, either with health services or with the police, also discourages their use. Violations of patient confidentiality have been frequently documented in countries that maintain such registries, with police obtaining identifying information and using it to target individuals *(33)*. Arresting people who inject drugs when they contact emergency services for assistance with an overdose is another discouraging practice *(34)*.

In some countries, law enforcement personnel are actively calling for change. For example, the Center for Law Enforcement and Public Health and the Law Enforcement Action Partnership have prepared a police statement of support for drug policy reform that calls for decriminalization and harm reduction *(35)*.

Compulsory treatment

Twelve UN agencies, the INCB and numerous UN human rights mechanisms and bodies have called for the closure of compulsory drug detention and treatment centres *(38–40)*.[8] The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has committed to not funding compulsory treatment programmes or facilities, and both the UN Working Group on Arbitrary Detention and the Committee on the Elimination of Discrimination against Women (CEDAW) have expressed concern at the continuing practice in some countries of incarcerating pregnant women who use drugs, either for involuntary treatment or punitive detention *(40–42)*.

However, at least 11 countries in South-East Asia and a number of countries in Latin America and the Caribbean continue to detain people who use drugs in compulsory drug detention centres *(18)*. These facilities have been linked to torture, forced labour and other abuses *(43)*. In South-East Asia, an estimated 450 000 people were detained in 948 compulsory drug detention centres in 2017 alone *(44)*. According to Harm Reduction International, the practice is escalating in some countries *(18)*. Other countries provide little or no state supervision to similarly abusive centres in the private sector *(20)*.

Stigma and discrimination and privacy

Stigma and discrimination in health-care settings undermines access to services for people who use drugs *(45, 46)*. Stigma is reinforced by criminal laws, policing and other

7. For example, see: The Committee on Economic, Social and Cultural Rights. Concluding observations on the combined fifth and sixth periodic reports of the Philippines. UN Doc. E/C.12/PHL/CO/5-6. 26 October 2016; CESCR. Concluding observations on the combined second to fourth periodic reports of the former Yugoslav Republic of Macedonia, UN Doc. E/C.12/MKD/CO/2-4 (2016); CEDAW. Concluding observations on the combined fourth and fifth periodic reports of Georgia, UN Doc. CEDAW/C/GEO/CO/4-5; and CRC. General comment 21 on children in street situations, UN Doc. CR/GC/21 (2017).
8. For a compilation of statements from 2008 to 2014, see: Amon J, Pearshouse R, Cohen J, Schleifer R. Compulsory drug detention in East and Southeast Asia: evolving government, UN and donor responses. Int J Drug Policy. 2014:25;13–20.

structural barriers that perpetuate violence, exploitation and a climate of fear. This undermines efforts to provide condoms and harm reduction services and to prevent the spread of HIV *(4, 6)*.

Some subpopulations of people who use drugs face multiple intersecting forms of stigma that render them more vulnerable to discrimination, violence and exploitation. For example, sex workers who use drugs may experience drug-related stigma from other sex workers and sex work-related stigma from people who use drugs. They also face greater risk of arrest or abuse by law enforcement *(47)*.

In 2016, UN Member States committed to ending HIV-related stigma and discrimination, including stigma and discrimination towards people who use drugs and other key populations *(48)*.

At its 2016 Special Session on the World Drug Problem, the UN General Assembly encouraged states to "prevent social marginalization and promote non-stigmatizing attitudes, as well as to encourage drug users to seek treatment and care, and take measures to facilitate access to treatment and expand capacity" *(3)*. In 2017, 12 UN agencies issued a Joint UN Statement on Ending Discrimination in Health Care Settings, recognizing discrimination

CASE STUDY: CALLING FOR CHANGE IN WEST AFRICA

West Africa has long been affected by drug trafficking, with drug use recently on the rise. Countries in the region have been slow to react to this trend. In West Africa, only Senegal offers both needle–syringe programmes and opioid substitution therapy *(18)*.

In 2018, the West Africa Commission on Drugs took action, producing the Model Drug Law for West Africa. The Model Law builds upon international commitments at the 2016 United Nations Special Session on the World Drug Problem and on the Economic Community of West African States Action Plan to Address Illicit Drug Trafficking, Related Organized Crime and Drug Abuse in West Africa (2016–2020). The Model Law calls for the removal of criminal penalties for drug use or possession of drugs for personal use, and for strong protections against law enforcement abuses. It also recommends delivery of harm reduction services, including evidence-informed drug treatment, and calls on countries to ensure that the possession of syringes cannot be considered evidence of a crime *(56)*.

Olusegun Obasanjo, former President of Nigeria and Chair of the West Africa Commission on Drugs, says that while existing laws tend to criminalize drug users, evidence shows that jailing growing numbers of people who inject drugs is no solution: "On the contrary, it worsens health issues, and puts enormous pressure on the already overstretched criminal justice system" *(57)*.

The West Africa Commission on Drugs is an independent high-level drug policy group. Development of the Model Drug Law was supported by the Kofi Annan Foundation, the Global Commission on Drug Policy and the Open Society Initiative for West Africa. Regional drug policy reform is also championed by the West Africa Drug Policy Network, which unites more than 600 civil society organizations in 16 countries.

"The Model Drug Law is relevant globally. A good drug law in West Africa needn't look any different from one in Asia or eastern Europe," says Jamie Bridge of the International Drug Policy Consortium. "It was designed and developed for the region; it was based on an assessment of drug laws in the region; it was led by regional experts and opinion leaders. But it is not just a West African resource" *(58)*.

A volunteer from Prison Number 18 in Brănești, Republic of Moldova, helps run the needle–syringe exchange programme by exchanging non-sterile injecting equipment for sterile equipment. Along with sterile injecting equipment, inmates also have access to disinfectants, condoms and informational materials on HIV, hepatitis, tuberculosis and other infectious diseases. Credit: UNAIDS.

as "a major barrier to the achievement of the Sustainable Development Goals" *(15)*. In March 2018, the CND passed a resolution calling on countries to develop policies to improve the accessibility, availability and delivery of health care and social services for people who use drugs. The resolution also states that governments should work to reduce stigmatizing attitudes within agencies and any possible discrimination, exclusion or prejudice those people might encounter *(2)*.

In November 2018, the United Nations Development Program (UNDP), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), UNAIDS and the Global Network of People Living with HIV launched the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination, including against people who use drugs. The goal of the partnership is to encourage commitments and actions to remove the barriers to health care and other services created by stigma and discrimination *(49)*.

UNAIDS has previously identified seven key programmes to remove stigma and discrimination and increase access to justice that can be adapted to the context of people who use drugs:

1. Stigma and discrimination reduction.
2. Accessible and appropriate legal services.
3. Monitoring and reforming laws, regulations and policies relating to people who use drugs.
4. Legal literacy ("know your rights").
5. Sensitization of law-makers and law enforcement agents.
6. Training for health-care providers on human rights and medical ethics related to people who use drugs.
7. Reducing discrimination against women in the context of drugs *(50)*.

Support and guidance for a human rights-based approach to drug policy

Since 2016, a growing chorus of UN agencies and international and regional human rights mechanisms has called for a human rights-based approach to drug policy *(14, 51)*. In 2018, the UN Common Position on International Drug Policy reiterated the United Nations'

CASE STUDY:
LAW ENFORCEMENT FOR A CHANGE

Law Enforcement Assisted Diversion (LEAD) is a project in the city of Seattle in the United States of America that provides an alternative to criminal penalties for the possession of under three grams of drugs for personal use. Instead of charging individuals with criminal possession, police officers establish a contact for the person with a case manager. Case managers help LEAD clients, many of whom are homeless or unemployed, receive support services such as housing, job placement and drug treatment *(66)*.

Harm reduction is a core principle of LEAD. Recognition of the critical importance of social determinants of health and providing social protection services to people who inject drugs has helped LEAD achieve impressive outcomes. Research shows that LEAD participants were 60% less likely to be arrested during the six months subsequent to evaluation entry, and that they were both 58% less likely to be arrested and 39% less likely to be charged with a felony over the longer term compared to persons not in the programme *(67)*. Moreover, among LEAD participants, access to housing and employment were associated with 17% and 33% fewer arrests during the follow-up, respectively *(68)*.

LEAD has built collaborations with police, prosecutors, civil rights advocates, public defenders, political leaders, mental health and drug treatment providers, and housing agencies. After a pilot phase, which included a randomized controlled trial, LEAD has scaled up across the United States, with programs in 32 cities and 19 states.

"strong commitment to supporting Member States in developing and implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented and sustainable responses to the world drug problem, within the framework of the 2030 Agenda for Sustainable Development" *(52)*.

With this increasing level of agreement on how to approach the issue has come a need for guidance on how to implement it *(53)*. Examples of best practices, model laws and policies are now available:

- The WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, which was updated in 2016 *(54)*.
- The forthcoming *International guidelines on human rights and drug policy*, which articulates that drug policy should be informed by a number of rights, such as the rights to health, life, privacy, an adequate standard of living, fair trial, freedom from torture and participation in cultural life *(53)*.
- The European Commission recommendations on alternatives to coercive sanctions for drug-related crime *(55)*.
- The West African Commission on Drugs Model Drug Law for West Africa, which calls for the protection of various human rights and provides an example of decriminalization of the possession, cultivation, transport and purchase of drugs for personal use (see text box on page 37). *(56)*.

A selection of UN and regional publications and resolutions that articulate a human rights-based approach to drug policy can be found in Annex 5.

Social protection

People who use drugs may have complex health and social needs. They are more likely to be homeless, unemployed, living in poverty, facing mental health difficulties and experiencing multiple forms of violence *(20, 59, 60)*. They are often excluded from social protection services that could help them overcome these challenges, including housing, educational grants and welfare payments. Some countries have been known to make welfare benefits conditional on drug testing, a practice that UN human rights mechanisms have condemned *(61, 62)*.

Subsidized housing for homeless people, access to food and nutrition programmes, and free access to transportation are all important measures that can increase the use of (and retention in) HIV care for people who use drugs *(68)*. In Hong Kong, the Support Fund for HIV/AIDS Patients and Their Families provides temporary financial assistance to cover basic needs, special medical expenses and travel expenses to receive care and other needs *(64)*. In Portugal, reintegration teams help individuals recovering from drug dependence find employment and housing *(65)*.

THE ROLE OF COMMUNITIES

4

THE ROLE OF COMMUNITIES

In the global effort to promote rights- and health-based approaches to drug use, especially in places where repressive policies and practices are the norm, civil society is an essential source of information, mobilization, advocacy and life-saving services.

Community-led mobilization has helped to shape and drive policy progress in many parts of the world. Since 2013, the international Support Don't Punish campaign has mobilized thousands of people in more than 100 cities to take part in a global day of action for health- and rights-based drug policies. From a bicycle rally of activists and law enforcement agents in Pokhara, Nepal, to a giant mural in the centre of Melbourne, Australia, and high-level policy dialogues in Paris and Phnom Penh, the Support Don't Punish campaign has mobilized and convened advocates around the world *(1)*. Mothers of people who use drugs have also emerged as a force for reform: in 2018, the Listen to Mom campaign brought together mothers' groups from Canada, Mexico and the United States of America to advocate for the end of criminalization and for harm reduction services *(2)*.

At the national level, advocates have supported capacity-building and dialogue with government officials. Civil society advocates participated in national drug policy dialogues in Ukraine, provided training for members of the National Commission to Combat Drugs in the Republic of Moldova, and organized a successful visit by Moldovan government officials to Portugal *(3, 4)*. In the Russian Federation, civil society has played an active role in creating a body of treaty recommendations directed at the government in relation to both drug policy and the increasing restrictions that have been placed on civil society *(5)*.

At the regional level, civil society advocacy has played a critical role in changing attitudes and discourse on drug policy and approaches to protecting and improving the health of people who use drugs. In the Middle East and North Africa, the Middle East and North Africa Harm Reduction Association promotes harm reduction to government officials and religious leaders *(7)*.

"WE CANNOT ISOLATE DRUG POLICY FROM THE GLOBAL POLITICAL CONTEXT, IN WHICH THE RHETORIC OF CONTROL, REPRESSION AND EXCLUSION HAS BECOME DOMINANT IN RECENT YEARS. POLITICAL POPULISM HAS NEGATIVE CONSEQUENCES FOR HARM REDUCTION AND DRUG POLICY."

Peter Sarosi, European Union Civil Society Forum on Drugs *(23)*

A participant at a meeting of a self-support group for people who inject drugs convened by the association Le Foyer du Bonheur in Côte d'Ivoire. Credit: Global Fund/Georges Mérillon.

Civil society in eastern Europe and central Asia has advanced hepatitis C treatment by pushing for the registration of and access to new direct-acting antiviral treatment *(8)*. As part of a European Union-funded project in three Baltic states, civil society worked together with governmental agencies to develop a methodology for drug policy impact assessment, using these results to inform the development of a national drug policy strategy *(9)*.

Globally, harm reduction policies have progressed, in part thanks to persistent advocacy and the development of new, broader coalitions. Civil society organizations led by people who use drugs, harm reduction advocates, human rights advocates and allied nongovernmental organizations have worked together to submit shadow reports to United Nations (UN) human rights treaty bodies, leading those mechanisms to submit stronger recommendations to countries *(10–15)*. International human rights institutions and women's organizations have also put out stronger positions and calls to action on drug policy reform *(16–18)*.

Civil society also plays a vital role in delivering harm reduction services to the people who need them. As new drugs emerge, new types of peer-led services also appearing. These can include sharing information on safer drug use techniques and the administration of naloxone. They can also include drug checking, providing vitamins and fluids, and offering many forms of psychological support. In Saint Petersburg, Russian Federation, nongovernmental organizations such as EVA work with smaller nonprofit organizations to provide peer outreach services and monitor funding for HIV programmes serving key populations *(19, 20)*.

The outcome document from the 2016 Special Session on the World Drug Problem reiterated the role of civil society and affected populations in the formulation, implementation and evaluation of drug policies and programmes. Financing this work continues to be a challenge in many countries. The 2016 Political Declaration on Ending AIDS committed to ensuring that 30% of the HIV response was community-led, and that 6% of all HIV financing was dedicated to social enablers, including advocacy and community mobilization *(21)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has similarly set key performance indicators for its current strategy, committing to

increasing funding for programmes that address human rights barriers to services, especially in middle-income countries *(22)*.

However, limited financing and narrowing civic space in many countries creates numerous challenges to civil society engagement. As donors transition out of middle-income countries, financing for civil society to engage in drug policy and provide harm reduction services is frequently at risk. In Bulgaria, for example, the funding allocated in the national HIV response for key populations is less than half of the amount previously provided by the Global Fund *(24)*. As part of sustainability planning, donors and recipient countries should ensure continuity of funding before they begin transition processes. Many civil society organizations are focusing advocacy on this issue and collaborating with groups that are experienced in this area. The Eurasian Harm Reduction Association's (EHRA) *Budget advocacy* guide is the result of one such partnership *(25)*.

In social contracting, government agencies contract services to civil society service providers *(27)*. Unfortunately, civil society organizations that represent or serve the needs of people who use drugs often face institutional barriers to registration and operation. In several countries, increasingly restrictive regulations have limited their work *(28)*. In the Russian Federation, for example, civil society organizations have been required to register as foreign agents because they received funding from international donors *(29, 30)*. It is critical that countries begin to develop social contracting systems and policies as they prepare to transition from donor support; this will help to ensure that life-saving services are not abruptly shuttered.

CASE STUDY: HIV PREVENTION AMONG PEOPLE WHO INJECT DRUGS IN THE RUSSIAN FEDERATION

The Russian Federation has one of the largest populations of people who inject drugs in the world, and also a growing HIV epidemic: from an estimated 95 000 new infections (among all ages) in 2015 to 100 000 in 2017. In 2017, HIV prevalence among people who inject drugs in six cities was 75.2% *(31)*. However, federal laws prohibit the provision of opioid substitution therapy, and nongovernmental organizations that receive international funding may be listed as foreign agents.

Until 2018, HIV prevention needle–syringe programmes were provided in only 17 cities. However, in Saint Petersburg, the Russian Federation's second largest city, civil society organizations have succeeded in forging a partnership with local authorities and obtaining government funding *(32–33)*.

Since 2001, the nongovernmental organization Humanitarian Action has offered a needle–syringe programme through a mobile unit, along with rapid HIV testing and counselling, referral to medical treatment for HIV and tuberculosis, and naloxone distribution. It has specific interventions for female sex workers who use drugs and for pregnant women who inject drugs. In 2018, Humanitarian Action provided HIV prevention services to more than 30 000 people, with approximately half of all clients being people who inject drugs *(34)*.

In recent years, Saint Petersburg is one of the only cities and regions in the Russian Federation that has reported a consistent decrease in new HIV infections, including among people who inject drugs.

According to Sergey Dugin, the director of Humanitarian Action, "Saint Petersburg implements a test-and-treat approach for HIV." For hepatitis C, he says, the picture is less rosy: "Only one or two of our clients got treatment" for hepatitis C coinfection in the previous year. "There is simply no budget for it" *(34)*.

"IN THE PROCESS OF TRANSITION FROM DONOR TO NATIONAL FUNDING, HARM REDUCTION AND OPIOID SUBSTITUTION THERAPY PROGRAMMES ARE THE FIRST AT THE RISK OF DISCONTINUATION. IN KAZAKHSTAN IN 2018, WE MANAGED TO PRESERVE THE NATIONAL OPIOID SUBSTITUTION THERAPY PROGRAMME LARGELY DUE TO THE FACT THAT CLIENTS INITIATED A CAMPAIGN AGAINST OPIOID SUBSTITUTION THERAPY CLOSURE . . . AND THE KAZAKHSTAN GOVERNMENT TOOK THESE ARGUMENTS INTO CONSIDERATION, SO THE CURTAILMENT ORDER WAS CANCELLED. BY THE BEGINNING OF 2019, THE ENROLMENT OF NEW CLIENTS FOR THE OPIOID SUBSTITUTION THERAPY PROGRAMME HAD STARTED."

Oxana Ibragimova, Steering committee member, representative of Central Asia, Kazakhstan Network of People Living with HIV) *(26)*

CONCLUSION

The overarching objective of the global drug control framework is the health, well-being and security of individuals. The interpretation of this objective into a criminalization and law enforcement approach has demonstrably failed to achieve global targets to "eliminate or reduce significantly and measurably" the supply and demand for illicit drugs by 2019. UNODC data show that the drug trade and drug use have not decreased in the 10 years since these targets were included in the 2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy.

Worse, the punitive approach has caused untold harm to people who use drugs and their families, and it has resulted in wider human, economic and environmental costs. Rates of HIV, viral hepatitis and tuberculosis remain high among people who use drugs, and violence and overdose have taken countless lives.

Comprehensive harm reduction services—including needle–syringe programmes, drug dependence treatment, overdose prevention with naloxone, and testing and treatment for HIV, tuberculosis, and hepatitis B and C—is what is needed to secure the health and well-being of people who use drugs. The decriminalization of drug use and possession for personal use has been shown to facilitate access to harm reduction services and improve rights protections for people who use drugs.

As a new chapter in the response to the world drug problem begins, UNAIDS calls on countries to adopt the recommendations contained within this report, and to rapidly transform those commitments into laws, policies, services and support that allow people who use drugs to live healthy and dignified lives.

ANNEX 1

Number of needle–syringes distributed per person who injects drugs, per year, by needle–syringe programmes, 2011–2017

<100 100–200 >200

Country	2011	2012	2013	2014	2015	2016	2017
Afghanistan	80	119	92	80			
Albania	90			6	7	7	
Armenia	28		44	54	65	72	76
Australia	203				268	625	
Azerbaijan	11	10	16	26	23	10	35
Bangladesh	264	237	287	224	243	157	125
Belarus	48	21	37		64	41	70
Bosnia and Herzegovina	26	51	24	100	88	142	
Bulgaria	22	21	14	13	36	21	
Cambodia	120	129	326	253	371	382	305
China	180	193		204		208	
Czechia	202				200	204	
Estonia	153		242	235	237	230	
Finland	202		196		281	361	
Georgia	22	23	45	79	80	91	73
Greece	7	56	53	69	52		
Hungary	114	74	114	76			
India	387	163	193	240	259	284	424
Indonesia	7	22	26	44	13	9	3
Iran (Islamic Republic of)	30	74	63	51	34		50
Kazakhstan	154	190	224	189	128	120	129
Kenya			15		72	155	189
Kyrgyzstan	151	253	292	252	241	153	224
Lao People's Democratic Republic		17	30				3
Latvia	19		33	49	62	93	
Lithuania	32		58	52	65	102	
Madagascar	0	0	0	0	0	0	8
Malaysia	1	43		31		26	14
Malta	302		212		475		
Mauritius	31	50	46	107	123		91
Mexico	7	12	20	4	7	6	6
Morocco	44	75	68	80	99	54	69
Myanmar	118	116	147	168	223	313	358
Nepal	71	36	31	36	25		61
North Macedonia	23	28		33			62
Pakistan	42	98	131	194	194	51	49
Poland	78	47	34				
Republic of Moldova	58	60	65	68	78	88	79
Romania	49	52	194	187	198	166	
Serbia	4	5	16				
Seychelles	0					6	9
Tajikistan	88	199	175	214	283	345	273
Thailand	10	12	12	14	6	13	13
Tunisia	15	9	5	15	27	17	41
Ukraine	75		77	66	63	71	84
United Republic of Tanzania			41		14	17	15
Uzbekistan	54	68	68	62	62		119
Viet Nam	140	180	98		62	148	149

Source: UNAIDS Global AIDS Monitoring, 2011–2017.

ANNEX 2

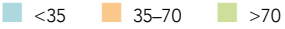
Number of people who inject drugs receiving opioid substitution therapy, 2015–2017

Country	2015	2016	2017	Increase in the number of people who inject drugs and are receiving opioid substitution therapy
Afghanistan	68	270	748	680
Albania	578	605	751	173
Armenia	480	495	501	21
Azerbaijan	168	113	224	56
Bangladesh	595	801	875	280
Belarus	978	869	770	-208
Georgia	1008	4736	7905	6897
India	22 320	23 500	25 400	3080
Iran (Islamic Republic of)	24 662	32 019	21 789	-2873
Kazakhstan	292	423	529	237
Kenya	870	1620	2467	1597
Kyrgyzstan	1234	1203	1232	-2
Malaysia	41 152	54 776	99 481	58 329
Mauritius	4614	4328	4379	-235
Myanmar	10 290	12 474	13 441	3151
Republic of Moldova	468	505	497	29
Senegal	108	155	199	91
Serbia	4336	4995	5404	1068
Seychelles	332	445	155	-177
Tajikistan	572	555	654	82
Ukraine	8512	9214	10189	1677
United Republic of Tanzania	3376	2647	1139	-2237
Viet Nam	43 720	50 358	53 000	9280

Source: UNAIDS Global AIDS Monitoring, 2011–2017.

ANNEX 3

Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse, 2011–2017



Country	2011	2012	2013	2014	2015	2016	2017
Armenia	43.7	33.1		41.7		54.9	
Belarus	53		41.4		59.5		51.5
Benin		52.9	41.8		30.8		51.8
Bosnia and Herzegovina	32.4	30.8			35.2		
Bulgaria	40	59	58			34	
China	40.4	43.1		44.8	61.3		
Estonia	36.2		38.9	56.1		48.7	
Georgia	22.4	34.5			35.6		36.5
Germany	30.6		54.4	41	38		
Greece				46.5	47.7		40
Hungary	28.6	20.4		22.1			
Japan	35.7			65.9	40		
Kazakhstan	47.2	50.6	54	48.9	49.8	47.9	
Kyrgyzstan	49.4		39.9			58.8	
Latvia	55.6		55.5	66.8		62.5	60
Madagascar	41.3		41.4			41.8	
Malaysia	27.8	26.7		20.8			25.7
Mauritius	25		38.2				45.4
Morocco	31.4		30	31.8	28.2		44.6
Nepal	46.5				52.5		48.9
North Macedonia	54.4			46.5			39.8
Philippines	15		13.4	12.9	14.5		
Senegal	35.8		38.5				42.7
Serbia	32	30.6	32.4				
Tajikistan	39.6	51.9		49.9			
Thailand	46.1	49.1		47.2			
Tunisia	19.3			29.3			46.7
Ukraine	47.8		54.1		48		43.9
Uzbekistan	42.8		50.1		45.1		
Viet Nam	51.9	48.9	41.2	59	38.1	36.5	43.7

Source: UNAIDS Global AIDS Monitoring, 2011–2017.

ANNEX 4

Indicator	Naloxone available through community distribution (reported by national authorities), 2017	Naloxone available through community distribution (reported by civil society representatives and other nongovernmental partners), 2017	Naloxone peer distribution programme operational, 2017
Sources	National commitments and policy instrument. Geneva: UNAIDS; 2018.		Stone K, Shirley-Beavan S. Global state of harm reduction, 2018. London: Harm Reduction International; 2018.
Afghanistan	No	Yes	Yes
Albania		No	
Algeria	No		
Antigua and Barbuda	No	No	
Argentina	No	No	
Armenia	No	No	
Australia			Yes
Azerbaijan	No		
Bahamas	No	No	
Bangladesh	No	No	
Barbados		No	
Belarus	No	No	
Benin	No	No	
Bolivia (Plurinational State of)	No	No	
Botswana	No	No	
Brazil	No		
Burundi	No	No	
Cambodia	Yes	No	
Cameroon		No	
Canada			Yes
Central African Republic	No	No	
Chile	No	No	
China	Yes	Yes	
Colombia	No	No	
Comoros	No	No	
Costa Rica	No	No	
Cuba	No	No	
Côte d'Ivoire	No	No	
Czechia	No	Yes	
Denmark			Yes
Dominica	No	No	
Dominican Republic	No	No	
El Salvador	No	No	
Equatorial Guinea	No	No	
Estonia			Yes
Eswatini	No	No	
Ethiopia	No	No	

Fiji	No	No	
Gabon	No	No	
Georgia	Yes	Yes	
Germany	Yes	Yes	
Ghana	No	No	
Guatemala		Yes	
Guinea	No	No	
Haiti		No	
Honduras	No	No	
Iceland	Yes	Yes	
India	Yes		
Iran (Islamic Republic of)	Yes	Yes	
Ireland	Yes	Yes	
Italy			Yes
Jamaica	No	No	
Kazakhstan	No	Yes	
Kenya	No	No	
Kiribati	No	No	
Kuwait	No	No	
Kyrgyzstan	Yes	Yes	
Lao People's Democratic Republic	No	No	
Latvia	No	No	
Lesotho	No		
Liberia	No	No	
Libya	No	No	
Lithuania	No	No	
Luxembourg	No	No	
Madagascar	No	No	
Malawi	No	No	
Malaysia	Yes		
Mali	No	No	
Malta	Yes		
Marshall Islands	Yes	No	
Mauritius	No	No	
Mexico	No	No	Yes
Micronesia (Federated States of)	No	No	
Montenegro	Yes	No	
Morocco	No	Yes	
Mozambique	No	No	
Myanmar	No	No	
Namibia	No	No	
Nauru	No		
Nepal	No	Yes	

New Zealand	No		
Nicaragua	No	No	
Niger	No	No	
Nigeria	No	No	
Niue	No	No	
Norway			Yes
Oman	Yes	Yes	
Pakistan	No	No	
Palau	No		
Panama	No	No	
Papua New Guinea	No	No	
Paraguay	Yes	No	
Philippines	No	No	
Republic of Moldova	Yes	Yes	
Rwanda	No	No	
Saint Lucia	No	No	
Samoa	No	No	
Saudi Arabia	No	No	
Senegal	No	No	
Serbia	No	No	
Seychelles	No	No	
Sierra Leone	No	No	
South Africa	Yes	No	
South Sudan	No	No	
Spain	Yes	No	
Sri Lanka	No	No	
Sudan		No	
Suriname	No		
Syrian Arab Republic	No		
Tajikistan	Yes	Yes	
Togo	No	No	
Tonga	No	No	
Tunisia		No	
Tuvalu	No	No	
Uganda	No	No	
Ukraine	No	No	Yes
United Kingdom			Yes
United Republic of Tanzania	No	No	
United States			Yes
Uruguay	No	No	
Vanuatu		No	
Venezuela (Bolivarian Republic of)	No	No	
Zambia	No	No	
Zimbabwe	No	No	

ANNEX 5

United Nations documents providing guidance and best practices on human rights and drug policy

1. United Nations Development Programme, The International Centre for Human Rights and Drug Policy. International guidelines on human rights and drug policy. New York: United Nations Development Programme (UNDP); 2019.

2. Global Commission on HIV and the Law. HIV and the law: risks, rights & health. 2018 supplement. New York: (UNDP); 2018 (https://hivlawcommission.org/supplement/).

3. United Nations High Commissioner for Human Rights (OHCHR). Implementation of the Joint Commitment to effectively Addressing and Countering the World Drug Problem with Regard to Human Rights. A/39/39, September 2018.

4. UNAIDS. Confronting discrimination. Geneva: UNAIDS; 2017 (http://www.unaids.org/en/resources/documents/2017/confronting-discrimination).

5. UNAIDS. Fast-Track and human rights — advancing human rights in efforts to accelerate the response to HIV. Geneva: UNAIDS; 2017.

6. Joint United Nations statement on ending discrimination in health care settings. In: who.int [website]. 27 June 2017. UNAIDS; c2019 (http://www.unaids.org/en/resources/documents/2017/ending-discrimination-in-health-care-settings).

7. United Nations Population Fund (UNFPA) Eastern Europe and Central Asia, International Planned Parenthood Federation (IPPF) European Network. Health, rights and well-being: a practical tool for HIV and sexual and reproductive health programmes with young key populations in eastern Europe and central Asia. UNFPA Eastern Europe and Central Asia, IPPF European Network; 2017 (https://eeca.unfpa.org/en/publications/health-rights-and-well-being).

8. World Health Organization (WHO), UNAIDS. Consolidated guidelines on HIV prevention, treatment and care for key populations. Geneva: WHO; 2016 (https://www.who.int/hiv/pub/guidelines/keypopulations/en/).

9. United Nations Office on Drugs and Crime (UNODC), The International Network of People who use Drugs (INPUD). Addressing the specific needs of women who inject drugs: practical guide for service providers on gender-responsive HIV services. Vienna: UNODC; 2016 (https://www.aidsdatahub.org/addressing-specific-needs-women-who-inject-drugs-practical-guide-service-providers-gender-responsive).

10. UNAIDS, UNODC. Guidance note: services for people who inject drugs. Geneva: UNAIDS; 2014.

11. International Labour Organization (ILO), UNAIDS, UNODC, UNFPA, UNHCR, UNICEF et al. Preventing and responding to HIV-related human rights crises: guidance for UN agencies and programmes. 2014 (https://www.aidsdatahub.org/sites/default/files/publication/Preventing_and_Responding_to_HIV_related_HR_crises_2014.pdf).

12. UNAIDS. Guidance note: reduction of HIV-related stigma and discrimination. Geneva: UNAIDS; 2014 (http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf).

13. Global Commission on HIV and the Law. HIV and the law: risks, rights & health. New York: UNDP; 2012 (https://hivlawcommission.org/report/).

14. UNAIDS. Guidance note. Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses. Geneva: UNAIDS; 2012 (http://www.unaids.org/sites/default/files/sub_landing/files/Key_Human_Rights_Programmes_en_May2012_0.pdf).

15. UNAIDS, OHCHR. International guidelines on HIV/AIDS and human rights. Consolidated version. Geneva: UNAIDS; 2006 (https://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf).

16. WHO. Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: WHO; 2017 (https://apps.who.int/iris/bitstream/handle/10665/254885/9789241549998-eng.pdf;jsessionid=B2CFD35CC4E4B89F2209B8E352003B6A?sequence=1).

REFERENCES

INTRODUCTION

1. World drug report 2018. Vienna: UNODC; 2019 (https://www.unodc.org/wdr2018/, accessed 18 February 2019).
2. Elie Aaraj, Middle East and North Asia Harm Reduction Network. Personal communication. 29 January 2019.
3. Resolution S-30/1. Our joint commitment to effectively addressing and countering the world drug problem. In: Thirtieth special session, New York, 4 May 2016 (A/RES/S-30/1; https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf, accessed 5 March 2019).
4. Resolution 70/266. Political Declaration on HIV and AIDS: on the Fast–Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. In: Seventieth session, New York, 22 June 2016 (A/RES/70/266; http://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf, accessed 5 March 2019).
5. Report 2017. Vienna: International Narcotics Control Board; 2017 (https://www.i ncb.org/documents/Publications/AnnualReports/AR2017/Annual_Report/E_2017_AR_ebook.pdf, accessed 18 February 2019).
6. Press release: INCB reiterates its call to States to consider the abolition of the death penalty for drug-related offences. In: INCB.org [website]. 1 August 2016. Vienna: International Narcotics Control Board; c1995–2019 (https://www.incb.org/incb/en/news/press-releases/2016/press_release010816.html, accessed 18 February 2019).
7. Larney S, Peacock A, Leung J, Colledge S, Hickman H, Vickerman P et al. Global, regional and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review. The Lancet. 2017;5(12):PE1208–E1220.
8. UNAIDS HIV financial dashboard.
9. UNAIDS Global AIDS Response Progress Reporting and Global AIDS Monitoring reports, 2015–2018.
10. Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD et al. What is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track Approach. PLoS ONE. 2016;11(5):e0154893.
11. International Drug Policy Consortium (IDPC). Taking stock: a decade of drug policy—a civil society shadow report. London: IDPC; 2018 (https://idpc.net/publications/2018/10/taking-stock-a-decade-of-drug-policy-a-civil-society-shadow-report, accessed 5 March 2019).
12. United Nations Commission on Crime Prevention and Criminal Justice. World crime trends and emerging issues and responses in the field of crime prevention and criminal justice. In: Twenty-third session, Vienna, 12–16 April 2014 (E/CN.15/2014/5; https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf, accessed 5 March 2019).
13. The death penalty for drug offences: global overview 2018. London: Harm Reduction International; 2019.
14. European Centre for Disease Prevention and Control; WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2018: 2017 data. Denmark: World Health Organization; 2018 (https://ecdc.europa.eu/sites/portal/files/documents/hiv-aids-surveillance-europe-2018.pdf). Table 5.
15. Report to the General Assembly. UN Special Rapporteur on health, Anand Grover. In: Sixty-fifth session, New York, 6 August 2010 (A/65/255; https://undocs.org/en/A/65/255, accessed 3 March 2019). Para. 72.
16. Committee on Economic, Social and Cultural Rights. Concluding observations on the combined fifth and sixth periodic reports of the Philippines. United Nations Economic and Social Council; 26 October 2016 (E/C.12/PHL/CO/5-6). Para. 54.
17. African Commission on Human and Peoples' Rights. HIV, the law and human rights in the African human rights system: key challenges and opportunities for a rights-based system. Banjul (The Gambia): African Union; 2017.
18. Report of the United Nations High Commissioner for Human Rights. Study on the impact of the world drug problem on the enjoyment of human rights. In: Thirtieth session of the Human Rights Council, New York, 4 September 2015 (A/HRC/30/65; https://undocs.org/en/A/HRC/30/65, accessed 3 March 2019).
19. Implementation of the joint commitment to effectively addressing and countering the world drug problem with regard to human rights. In: Thirty-ninth session of the Human Rights Council, New York, 14 September 2018 (A/HRC/39/39; https://undocs.org/A/HRC/39/39, accessed 3 March 2019).
20. Tackling the world drug problem: UN experts urge States to adopt human rights approach. In: ohchr.org [website]. 18 April 2016. OHCHR; c1996–2019 (https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=19833&LangID=E, accessed 3 March 2019).

21. UNAIDS, UNHCR, UNICEF, WFP, UNDP, UNFPA et al. Joint United Nations statement on ending discrimination in health care settings. 2017 (http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf, accessed 4 March 2019).

22. Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (adopted at the high-level session of the fifty-second session, 2 March 2009, and by the General Assembly in its resolution A/RES/64/182 of 18 December 2009).

1. PEOPLE WHO USE DRUGS: A POPULATION UNDER ATTACK

1. World drug report 2018. Vienna: UNODC; 2019 (https://www.unodc.org/wdr2018/, accessed 18 February 2019).

2. UNAIDS special analysis.

3. Estimates provided by UNODC, 2016.

4. UN DESA/Population Division. World population prospects. 2017.

5. World drug report 2013. Vienna and New York: UNODC; 2013 (https://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf, accessed 18 February 2019).

6. Bruggmann P, Grebely J. Prevention, treatment and care of hepatitis C virus infection among people who inject drugs. Int J Drug Policy. 2015;26:S22–6.

7. Joint estimates by UNODC, WHO, UNAIDS and World Bank, 2017.

8. Global hepatitis report 2017. Geneva: WHO; 2017 (https://www.who.int/hepatitis/publications/global-hepatitis-report2017/en/, accessed 18 February 2019).

9. Key populations brief: people who use drugs. Geneva: Stop TB Partnership (http://www.stoptb.org/assets/documents/resources/publications/acsm/kp_peopleusedrugs_spreads.pdf, accessed 18 February 2019).

10. Getahun H, Gunneberg C, Sculier D, Verster A, Raviglione M. Tuberculosis and HIV in people who inject drugs: evidence for action for tuberculosis, HIV, prison and harm reduction services. Curr Opin HIV AIDS. 2012;7(4):345–53.

11. Efsen AMW, Schultze A, Miller RF, Panteleev A, Skrahin A, Podlekareva DN et al. Management of MDR-TB in HIV co-infected patients in Eastern Europe: results from the TB:HIV study. J Infect. 2018;76(1):44–54.

12. Podlekareva DN, Efsen AMW, Schultze A, Post FA, Skrahina AM, Panteleev A et al. Tuberculosis-related mortality in people living with HIV in Europe and Latin America: an international cohort study. Lancet HIV. 2016;3(3):e120–e131.

13. Global state of harm reduction 2018. London: Harm Reduction International; 2018 (https://www.hri.global/global-state-harm-reduction-2018, accessed 18 February 2019).

14. Committee on the Elimination of Discrimination against Women. Concluding observations on the combined eighth and ninth periodic reports of Canada. 25 November 2016 (CEDAW/C/CAN/CO/8-9; https://undocs.org/en/CEDAW/C/CAN/CO/8-9, accessed 3 March 2019). Para. 44.

15. Committee on the Elimination of Discrimination against Women. Concluding observations: Chile. 14 March 2018 (CEDAW/C/CHL/CO/7). Para. 48.

16. Visit to Nicaragua. Report of the Working Group on Arbitrary Detention. In: Fourth session of the Human Rights Council, New York, 9 November 2006 (A/HRC/4/40/Add.3; https://www.ohchr.org/EN/Issues/Detention/Pages/Visits.aspx) .

17. Svetlana Moroz, Svitanok Club. Personal communication. 18 January 2019.

18. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. Pediatrics. 2003;111(3):564–72.

19. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Mendéz. In: Sixty-eighth session, New York, 9 August 2013 (A/68/295; https://undocs.org/A/68/295). Paras. 47, 67, 68, 70.

20. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak. In: Thirtieth session of the Human Rights Council, New York, 5 February 2010 (A/HRC/13/39/Add.5; https://undocs.org/A/HRC/13/39/Add.5). Paras. 231, 257.

21. Background note: zero discrimination in health care settings. Geneva: UNAIDS; 2017 (http://www.unaids.org/sites/default/files/media_asset/20171129_UNAIDS_PCB41_Zero_discrimination-health-care-settings_17.27_EN.pdf, accessed 12 March 2019).

22. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014 (http://www.who.int/hiv/pub/guidelines/keypopulations/en/).

23. Kerr T, Shannon K, Ti L, Strathdee S, Hayashi K, Nguyen P et al. Sex work and HIV incidence among people who inject drugs. AIDS. 2016;30(4):627–34.

24. Campeau L, Blouin K, Leclerc P, Alary M, Morissette C, Blanchette C et al. Impact of sex work on risk behaviours and their association with HIV positivity among people who inject drugs in eastern central Canada: cross-sectional results from an open cohort study. BMJ Open. 2018;8(1):e019388.

25. Avila MM, dos Ramos Farías MS, Fazzi L, Romero M, Reynaga E, Marone R et al. High frequency of illegal drug use influences condom use among female transgender sex workers in Argentina: impact on HIV and syphilis infections. AIDS Behav. 2017:21(7):2059–68.

26. Sewell J, Miltz A, Lampe FC, Cambiano V, Speakman A, Phillips AN. Poly drug use, chemsex drug use and associations with sexual risk behaviour in HIV-negative men who have sex with men attending sexual health clinics. Int J Drug Policy. 2017;43:33–43.

27. Briefing paper: sex workers who use drugs. Experiences, perspectives, needs and rights: ensuring a joint approach. Global Network of Sex Work Projects, International Network of People Who Use Drugs; 2015 (https://www.inpud.net/sex_workers_who_use_drugs_nswp_inpud_oct_2015.pdf).

28. European Chemsex Forum. A call to action for effective responses to problematic chemsex. Position paper from organizers and participants of the 2nd European Chemsex Forum, Berlin, 22–24 March 2018 (https://ihp.hiv/).

29. McCall H, Adams N, Mason D, Willis J. What is chemsex and why does it matter? BMJ. 2015;351:h5790.

30. Pakianathan M, Whittaker W, Lee MJ, Avery J, Green S, Nathan B et al. Chemsex and new HIV diagnosis in gay, bisexual and other men who have sex with men attending sexual health clinics. HIV Med. 22 May 2018. Epub ahead of print (https://doi.org/10.1111/hiv.12629, accessed 4 March 2019).

31. Luo W, Hong H, Wang XF, McGoogan JM. Synthetic drug use and HIV infection among men who have sex with men in China: a sixteen-city, cross-sectional survey. PLoS ONE. 2018;13(7):e0200816.

32. Bourne A, Reid D, Hickson F, Torres-Rueda S, Steinberg P, Weatherburn P et al. "Chemsex" and harm reduction need among gay men in South London. Int J Drug Policy. 2015;26(12):1171–6.

33. Integrated biological & behavioral surveillance in Pakistan, 2016–17. Islamabad: National AIDS Control Program; April 2017 (https://www.nacp.gov.pk/repository/whatwedo/surveillance/Final%20IBBS%20Report%20Round%205.pdf, accessed 19 February 2019).

34. The drug killings: who, what, where, when, how? In: The Drug Archive. Ateneo School of Government at Ateneo de Manila University (https://drugarchive.ph/post/26-the-drug-killings-who-what-where-when-how-master, accessed 31 January 2019).

35. Philippines' "War on Drugs." In: Human Rights Watch [website]. New York: Human Rights Watch; c2019 (https://www.hrw.org/tag/philippines-war-drugs, accessed 4 March 2019).

36. Azim T, Bontell I, Strathdee SA. Women, drugs and HIV. Int J Drug Policy. 2015;26(1):s16–s21.

37. Gilbert L, Jiwatram Negron T, Nikitin D, Rychkova O, McCrimmon T, Ermolaeva I et al. Feasibility and preliminary effects of a screening, brief intervention and referral to treatment model to address gender based violence among women who use drugs in Kyrgyzstan: Project WINGS (Women Initiating New Goals of Safety). Drug Alcohol Rev. 2017;36(1):125–33.

38. Women speak out: understanding women who inject drugs in Indonesia. PKNI, the University of Oxford; 2016 (http://korbannapza.org/files/pdf/WomenSpeakOut_English_Web.pdf, accessed 4 March 2019).

39. Women who inject drugs and HIV: addressing specific needs. Vienna: UNODC; 2014.

40. Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Shirude S, Unützer J et al. Trends and patterns of geographic variation in mortality from substance use disorders and intentional injuries among US counties, 1980–2014. JAMA. 2018;319(10):1013–23.

41. Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2017. NCHS Data Brief No. 329. November 2018. Hyattsville (MD): US Department of Health & Human Services; 2018 (https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf, accessed 4 March 2019).

42. Overview of national data on opioid-related harms and death. In: Government of Canada—Health Canada [website]. 12 December 2018; updated 1 January 2019. Ottawa: Government of Canada (www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research/harms-deaths.html, accessed 4 March 2019).

43. Statistical bulletin 2018–overdose deaths. In: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [website]. Lisbon: EEMCDDA (http://www.emcdda.europa.eu/data/stats2018/drd).

2. HARM REDUCTION: LINKING HUMAN RIGHTS AND PUBLIC HEALTH

1. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: WHO, UNODC, UNAIDS; 2012.
2. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016 update. Geneva: WHO; 2016.
3. Potier C, Laprévote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 2014;145:48–68.
4. Abdul-Quader AS, Feelemyer J, Modi S, Stein ES, Briceno A, Semaan S et al. Effectiveness of structural-level needle/syringe programs to reduce HCV and HIV infection among people who inject drugs: a systematic review. AIDS Behav. 2013;17(9):2878–92.
5. Des Jarlais DC, Feelemyer JP, Modi SN, Abdul-Quader A, Hagan H. High coverage needle/syringe programs for people who inject drugs in low and middle income countries: a systematic review. BMC Public Health. 2013 Jan 19;13:53.
6. Global state of harm reduction 2018. London: Harm Reduction International; 2018 (https://www.hri.global/global-state-harm-reduction-2018, accessed 18 February 2019).
7. Vickerman P, Martin NK, Hickman M. Could low dead-space syringes really reduce HIV transmission to low levels? Int J Drug Policy. 2013;24:8–14.
8. Zule W, Pande PG, Otiashvili D, Bobashev GV, Friedman SR, Gyarmathy VA et al. Options for reducing HIV transmission related to the dead space in needles and syringes. Harm Reduct J. 2018;15(1):3.
9. Safiatou Thiam, Executive Secretary of the National Council for the Fight Against AIDS. Personal communication. 11 February 2019.
10. Pettes T, Wood E, Guillemi S, Lai C, Montaner J, Kerr T. Methadone use among HIV-positive injection drug users in a Canadian setting. J Subst Abuse Treat. 2010;39:174–9.
11. MacArthur GJ, Minozzi S, Martin N, Vickerman P, Deren S, Bruneau J et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. BMJ. 2012;345:e5945.
12. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C et al. Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta analysis. Addiction. 2018;113(3):545–63.
13. Ma J, Bao YP, Wang RJ, Su MF, Liu MX, Li JQ et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2018 Jun 22. Epub ahead of print (https://www.nature.com/articles/s41380-018-0094-5, accessed 4 March 2019).
14. Low AJ, Mburu G, Welton NJ, May MT, Davies CF, French C et al. Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic Review and Meta-Analysis. Clinical Infectious Diseases, Volume 63, Issue 8, 15 October 2016.
15. Handanagic S, Bozicevic I, Sekerija M, Rutherford GW, Begovac J. Overdose mortality rates in Croatia and factors associated with self-reported drug overdose among persons who inject drugs in three Croatian cities. Int J Drug Policy. 2019;64:95–102.
16. Nielsen S, Larance B, Degenhardt L, Gowing L, Kehler C, Lintzeris N. Opioid maintenance medicines for the treatment of dependence on opioid pain medicines. Cochrane Database Syst Rev. 2016;5:CD011117.
17. Castells X, Cunill R, Pérez-Mañá C, Vidal X, Capellà D. Efficacy of psychostimulant drugs for cocaine dependence. Cochrane Database Syst Rev. 2016;9:CD007380.
18. UNODC, WHO. Principles of drug dependence treatment. 2009.
19. Lagarde M, Palmer N. The impact of user fees on access to health services in low- and middle-income countries. Cochrane Database Syst Rev;2011;Apr 13(4):CD009094.
20. Shepherd A, Perrella B, Hattingh HL. The impact of dispensing fees on compliance with opioid substitution therapy: a mixed methods study. Subst Abuse Treat Prev Policy. 2014;9:32.
21. Johns B, Chao LB, Hanh KH, Manh PD, Do HM, Duong AT et al. Association between user fees and dropout from methadone maintenance therapy: results of a cohort study in Vietnam. Health Systems and Reform. 2018;4(2). doi: https://doi.org/10.1080/23288604.2018.1440347.
22. OST in Georgia today [website]. GENPUD; 2019 (http://genpud.ge/home/content?content_id=164).
23. The United Nations Mandela Rules, Rule 24.
24. Resolution S-30/1. Our joint commitment to effectively addressing and countering the world drug problem. In: Thirtieth special session, New York, 4 May 2016 (A/RES/S-30/1; https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf, accessed 5 March 2019).

25. Mission to Azerbaijan. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover. In: Twenty-third session of the Human Rights Council, New York, 3 May 2013 (A/HRC/23/41/Add.1; https://documents-dds-ny.un.org/doc/UNDOC/GEN/G13/135/32/PDF/G1313532.pdf?OpenElement). Para. 60.

26. Committee on the Elimination of Racial Discrimination. Concluding observations on the combined twenty-first to twenty-third periodic reports of Canada. 13 September 2017 (CERD/C/CAN/CO/21-23). Para. 16(e).

27. UNAIDS Global AIDS Monitoring data 2017.

28. Consolidated guidelines on HIV testing services. Geneva: WHO; 2015 (https://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/, accessed 4 March 2019).

29. Quality testing saves lives. In: World Health Organization [website]. 12 July 2015. Geneva: WHO; c2019 (https://www.who.int/westernpacific/news/feature-stories/detail/quality-testing-saves-lives, accessed 4 March 2019).

30. WHO, UNAIDS statement on HIV testing services: new opportunities and ongoing challenges. Geneva: WHO, UNAIDS; 2017 (http://www.unaids.org/sites/default/files/media_asset/2017_WHO-UNAIDS_statement_HIV-testing-services_en.pdf, accessed 4 March 2019).

31. Market and technology landscape: HIV rapid diagnostic tests for self-testing. Fourth edition. Geneva: WHO, UNITAID; 2018 (https://www.who.int/hiv/pub/self-testing/hiv-self-testing-2018-edition4/en/, accessed 4 March 2019).

32. Dalal S, Johnson C, Fonner V, Kennedy CE, Siegfried N, Figueroa C et al. Improving HIV testing uptake and case-finding with assisted partner notification services. AIDS. 2017;31:1867–76.

33. Guidelines on HIV self-testing and partner notification: supplement to consolidated guidelines on HIV testing services. Geneva: WHO; 2016.

34. Kan M, Garfinkel DB, Samoylova O, Gray RP, Little KM. Social network methods for HIV case finding among people who inject drugs in Tajikistan. J Int AIDS Soc. 2018;21(Suppl 5):e25139.

35. Smyrnov P, Williams LD, Korobchuk A, Sazonova Y, Nikolopoulos GK, Skaathun B et al. Risk network approaches to locating undiagnosed HIV cases in Odessa, Ukraine. J Int AIDS Soc. 2018;21(1):e25040.

36. Action plan: global action plan on HIV drug resistance, 2017–2021. 2018 progress report. Geneva: WHO; July 2018 (https://apps.who.int/iris/bitstream/handle/10665/273049/WHO-CDS-HIV-18.12-eng.pdf?ua=1, accessed 4 March 2019).

37. Low AJ, Mburu G, Welton NJ, May MT, Davies CF, French C et al. Impact of opioid substitution therapy on antiretroviral therapy outcomes: a systematic review and meta-analysis. Clin Infect Dis. 2016;63:1094–104.

38. United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, United States Agency for International Development. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017.

39. Health, rights and well-being. A practical tool for HIV and sexual and reproductive health programmes with young key populations in eastern Europe and central Asia. UNFPA, IPPF; 2017 (http://eeca.unfpa.org/sites/default/files/pub-pdf/IPPF_PROGRAMINGTOOLS_ENGLISH_FINAL.pdf).

40. Bazzi AR, Biancarelli DL, Childs E, Drainoni ML, Edeza A, Salhaney P et al. Limited knowledge and mixed interest in pre-exposure prophylaxis for HIV prevention among people who inject drugs. AIDS Patient Care STDS. 2018;32(12):529–37.

41. Guise A, Abrams E, Strathdee SA. "PrEP is not ready for our community and we are not ready for PrEP": pre-exposure prophylaxis for HIV for people who inject drugs and limits to the HIV prevention response. Addiction. 2017;112:572–8.

42. Shrestha R, Copenhaver M. Exploring the use of pre-exposure prophylaxis (PrEP) for HIV prevention among high-risk people who use drugs in treatment. Front Public Health. 2018;6:195.

43. Pre-exposure prophylaxis (PrEP). In: afao.org [website]. Newtown (Australia): Australian Federation of AIDS Organisations (https://www.afao.org.au/our-work/policy-and-submissions/prep/#people-who-inject-drugs, accessed 4 March 2019).

44. Guise A, Albers ER, Strathdee SA. Pre-exposure prophylaxis (PrEP) for people who inject drugs: reconciling community views and biomedical advances. Addiction. 2017;112(4):584–5.

45. Beyrer C. Commentary on Guise et al. (2017). Addiction. 2017;112:579–85.

46. Preexposure prophylaxis for the prevention of HIV infection in the United States—2017 update. A clinical practice guideline. Centers for Disease Control and Prevention, US Public Health Service; 2018 (https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf, accessed 4 March 2019).

47. BHIVA/BASHH guidelines on the use of HIV pre-exposure prophylaxis (PrEP) 2018. British HIV Association and BASHH; 2018 (https://www.bhiva.org/file/5b729cd592060/2018-PrEP-Guidelines.pdf, accessed 4 March 2019).

48. Integrating collaborative TB and HIV services within a comprehensive package of care for people who use drugs. Geneva: WHO; 2016.

49. Global hepatitis report 2017. Geneva: WHO; 2017.

50. Belani H, Chorba T, Fletcher F, Hennessey K, Kroeger K, Lansky A et al. Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services. Morb Mortal Wkly Rep (MMWR). 2012;61(RR05):1–40.

51. Bajis S, Dore GJ, Hajarizadeh B, Cunningham EB, Maher L, Grebely J. Interventions to enhance testing, linkage to care and treatment uptake for hepatitis C virus infection among people who inject drugs: a systematic review. Int J Drug Pol. 2017 (47) (https://www.sciencedirect.com/science/article/pii/S0955395917302049, accessed 4 March 2019).

52. Progress report on access to hepatitis C treatment: focus on overcoming barriers in low- and middle-income countries. Geneva: WHO; March 2018.

53. Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: WHO; 2015.

54. Wolfe D, Luhmann N, Harris M, Momenghalibaf A, Albers E, Byrne J et al. Human rights and access to hepatitis C treatment for people who inject drugs. Int J Drug Policy. 2015;26(11):1072–80.

55. Marshall AD, Cunningham EB, Nielsen S, Aghemo A, Alho H, Backmund M et al. Restrictions for reimbursement of interferon-free direct-acting antiviral drugs for HCV infection in Europe. Lancet Gastroenterol Hepatol. 2018 Feb;3(2):125–33.

56. Global Commission on HIV and the Law. HIV and the law: risks, rights & health. 2018 supplement. New York: UNDP; 2018.

57. Lazarus JV, Safreed-Harmon K, Stumo SR, Jauffret-Roustide M, Maticic M, Reic T et al. Restrictions on access to direct-acting antivirals for people who inject drugs: the European Hep-CORE study and the role of patient groups in monitoring national HCV responses. Int J Drug Policy. 2017;47:47–50.

58. Dillon, Lazarus JV, Razavi HA. Urgent action to fight hepatitis C in people who inject drugs in Europe. Hepatology, Medicine and Policy. 2016;1(2).

59. Grebely et al. 2017 Elimination of HCV as a public health concern among people who inject drugs by 2030 – what will it take to get there? J Int AIDS Soc. 2017 Jul 28;20(1):22146.

60. UNODC, International Network of People Who Use Drugs, UNAIDS, UNDP, UNFPA, WHO et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: UNODC; 2017 (https://www.unodc.org/unodc/en/hiv-aids/new/practical-guidance-for-collaborative-interventions.html, accessed 4 March 2019).

61. Latent TB infection: updated and consolidated guidelines for programmatic management. Geneva: WHO; 2018 (https://www.who.int/tb/publications/2018/latent-tuberculosis-infection/en/ page 2, accessed 4 March 2019).

62. McDonald R, Strang J. Are take home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. Addiction. 2016;111(7):1177–87.

63. Community management of opioid overdose. Geneva: WHO; 2014 (https://www.who.int/substance_abuse/publications/management_opioid_overdose/en/, accessed 4 March 2019).

64. Alltucker K. Drug company raised price of lifesaving opioid overdose antidote more than 600 percent. In: USAtoday.com [website]. 19 November 2018; updated 20 November 2018 (https://eu.usatoday.com/story/news/health/2018/11/19/kaleo-opioid-overdose-antidote-naloxone-evzio-rob-portman-medicare-medicaid/2060033002/, accessed 4 March 2019).

65. Madah-Amiri D, Gjersing L, Clausen T. Naloxone distribution and possession following a large-scale naloxone programme. Addiction. 2019;114(1):92–100.

66. National Services Scotland. National naloxone programme Scotland. Monitoring report 2016/2017. Revised edition. Information Services Division Scotland; May 2018 (https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2017-11-07/2017-11-07-Naloxone-Report.pdf, accessed 4 March 2019).

67. Bennett AS, Bell A, Doe-Simkins M, Elliott L, Pouget E, Davis C. J Psychoactive Drugs. 2018;50(3):240–246.

68. Welch E. A community of recovery. In: Center for American Progress [website]. 10 January 2019. Center for American Progress; c2019 (https://www.americanprogress.org/issues/criminal-justice/reports/2019/01/10/464889/a-community-of-recovery/, accessed 4 March 2019).

69. Lewis CR, Vo HT, Fishman M. Intranasal naloxone and related strategies for opioid overdose intervention by nonmedical personnel: a review. Subst Abuse Rehabil. 2017;2017(8):79–95.

70. Estonia. Country drug report 2018. In: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [website]. Lisbon: EMCDDA (http://www.emcdda.europa.eu/countries/drug-reports/2018/estonia/harm-reduction_en, accessed 4 March 2019).

71. Pardo B, Caulkins JP, Kilmer B. Assessing the evidence on supervised drug consumption sites. Santa Monica (CA): RAND Corporation; 2018 (https://www.rand.org/content/dam/rand/pubs/working_papers/WR1200/WR1261/RAND_WR1261.pdf, accessed 4 March 2019).

72. Annual report 2017. Vienna: International Narcotics Control Board; 2017.

73. Azim T, Bontell I, Strathdee SA. Women, drugs and HIV. Int J Drug Policy. 2015;26(Suppl 1):S16–21.

74. Csete J. "Second on the needle": human rights of women who use drugs. HIV/AIDS Policy Law Rev. 2006;11:66–7.

75. Pinkham S, Malinowska-Sempruch K. Women, harm reduction and HIV. Reprod Health Matters. 2008;16:168–81.

76. Drug User Peace Initiative: a war on women who use drugs. London: International Network of People Who Use Drugs (INPUD); 2015 (http://www.druguserpeaceinitiative.org/dupidocuments/DUPI-A_War_on_Women_who_Use_Drugs.pdf, accessed 4 March 2019).

77. Taking stock: a decade of drug policy—a civil society shadow report. London: International Drug Policy Consortium (IDPC); 2018 (https://idpc.net/publications/2018/10/taking-stock-a-decade-of-drug-policy-a-civil-society-shadow-report, accessed 18 February 2019).

78. Substance abuse treatment and care for women: case studies and lessons learned. Vienna: United Nations Office on Drugs and Crime (UNODC); 2004.

79. Call to action to attain universal health coverage through linked sexual and reproductive health and rights and HIV interventions. Geneva: WHO; 2018 (https://www.who.int/reproductivehealth/publications/call-to-action-linked-srhr-hiv-interventions/en/, accessed 4 March 2019).

80. Fischler F. Why drug policy is a feminist issue. In: AWID [website]. 14 November 2018. AWID; c2018 (https://www.awid.org/news-and-analysis/why-drug-policy-feminist-issue, accessed 4 March 2019).

81. A technical brief: HIV and young people who inject drugs. Geneva: WHO; 2015 (https://apps.who.int/iris/bitstream/handle/10665/179865/WHO_HIV_2015.10_eng.pdf;jsessionid=63F1B77BDFC35F8F46C73C765BDFD832?sequence=1, accessed 4 March 2019).

82. Code of practice for running safer music festivals and events. Melbourne: Victorian Government Department of Health, Mental Health and Drugs Division (https://www2.health.vic.gov.au/Api/downloadmedia/%7B672393DE-E7DB-4118-8C9F-7BD1D5F045DB%7D).

83. World drug report 2018. Vienna: UNODC; 2019 (https://www.unodc.org/wdr2018/, accessed 18 February 2019).

84. Wiessing L, Folch C. New psychoactive substances, drug injecting and sex in recreational settings—increased risk of HIV and HCV and opportunities for prevention. Revista Enfermedades Emergentes. 2016;15(2):57–61.

85. Tarján A, Dudás M, Wiessing L, Horváth G, Rusvai E, Tresó B. HCV prevalence and risk behaviours among injectors of new psychoactive substances in a risk environment in Hungary—an expanding public health burden. Int J Drug Policy. 2017;41:1–7.

86. Brunt T. Drug checking as a harm reduction tool for recreational drug users: opportunities and challenges. Lisbon: EMCDDA; 2017 (http://www.emcdda.europa.eu/system/files/attachments/6339/EuropeanResponsesGuide2017_BackgroundPaper-Drug-checking-harm-reduction_0.pdf, accessed 4 March 2019).

87. Marcus Day, Caribbean Drug and Alcohol Research Institute. Personal communication. 4 February 2019.

88. Eliza Kurcevic, Eurasian Harm Reduction Association. Personal communication. 10 February 2019.

89. Lim SH, Guadamuz TE, Altice FL. HIV prevention among MSM and transgender people who use drugs in Asia and the Pacific. HIV Australia. 2013;11(4) (https://www.afao.org.au/article/hiv-prevention-among-msm-transgender-people-use-drugs-asia-pacific, accessed 4 March 2019).

90. Briefing paper: sex workers who use drugs. Experiences, perspectives, needs and rights: ensuring a joint approach. Global Network of Sex Work Projects, International Network of People Who Use Drugs; 2015 (https://www.inpud.net/sex_workers_who_use_drugs_nswp_inpud_oct_2015.pdf).

91. Stardust Z, Kolstee J, Joksic S, Gray J, Hannan S. A community-led, harm-reduction approach to chemsex: case study from Australia's largest gay city. Sex Health. 2018;15(20):179–81.

92. Roux P, Fressard L, Suzan-Monti M, Chas J, Sagaon-Teyssier L, Capitant C et al. Is on-demand HIV pre-exposure prophylaxis a suitable tool for men who have sex with men who practice chemsex? Results from a substudy of the ANRS-IPERGAY Trial. JAIDS. 2018;79(2):69–75.

93. Thematic segment: mental health and HIV/AIDS – promoting human rights, an integrated and person-centred approach to improving art adherence, well-being and quality of life. Geneva: UNAIDS; 2018 (http://www.unaids.org/sites/default/files/media_asset/20181203_UNAIDS_PCB43_BN_thematic-segment-mental-health-and-HIV_EN.pdf, accessed 4 March 2019).

94. Olga Szubert, Harm Reduction International. Personal communication. 24 January 2019.

95. Gelareh Mostashari, UNODC. Personal communication. 25 January 2019.

96. UNAIDS HIV financial dashboard.

97. UNAIDS Global AIDS Response Progress Reporting and Global AIDS Monitoring reports, 2017–2018.

98. Dmitry Pinevich, First Deputy Minister of Health, Republic of Belarus. Personal communication. 6 February 2019.

99. Transforming our world: the 2030 agenda for sustainable development. In: Seventieth session, New York, 21 October 2015 (A/RES/70/1; https://sustainabledevelopment.un.org/post2015/transformingourworld).

100. Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD. What is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track approach. PLOS ONE. 2016:11(6);e0158253.

101. Chapter 6: health care systems and substance use disorders. In: Facing addiction in America. The Surgeon General's report on alcohol, drugs and health. Washington (DC): US Department of Health and Human Services; 2016 (https://www.ncbi.nlm.nih.gov/books/NBK424848/, accessed 4 March 2019).

102. Metsch L, Philbin MM, Parish C, Shiu K, Frimpong JA, Giang le M. HIV testing, care and treatment among women who use drugs from a global perspective: progress and challenges. J Acquir Immune Defic Syndr. 2015;69 Suppl 2:S162–8.

103. van Boekel LC, Brouwers EP, van Weeghel J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug Alcohol Depend. 2013 Jul 1;131(1–2):23.

3. OVERCOMING THE HUMAN RIGHTS BARRIERS TO HEALTH, DIGNITY AND WELL-BEING

1. CND Resolution 61/6. Promoting the implementation of the United Nations Guiding Principles on Alternative Development and related commitments on alternative development and regional, interregional and international cooperation on development-oriented, balanced drug control policy addressing socioeconomic issues (2018). In: Sixty-first session, Commission on Narcotic Drugs, New York, 8 December 2017 and 12–16 March 2018.

2. Resolution 61/11. Promoting non-stigmatizing attitudes to ensure the availability, access and delivery of health, care and social services for drug users. In: Sixty-first session, Commission on Narcotic Drugs, New York, 8 December 2017 and 12–16 March 2018.

3. Our joint commitment to effectively addressing and countering the world drug problem. In: Thirtieth special session, New York, 4 May 2016 (https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf, accessed 5 March 2019).

4. DeBeck K, Cheng T, Montaner JS, Beyrer C, Elliott R, Sherman S et al. HIV and the criminalization of drug use among people who inject drugs: a systematic review. Lancet HIV. 2017;4:e357–74.

5. Global Commission on HIV and the Law. HIV and the law: risks, rights & health. 2018 supplement. New York: UNDP; 2018.

6. Strathdee SA, Beletsky B, Kerr T. HIV, drugs and the legal environment. Int J Drug Pol. 2015;26(1):S27–S32 (https://www.sciencedirect.com/science/article/pii/S0955395914002631, accessed 4 March 2019).

7. Stauffer B. Every 25 seconds: the human toll of criminalizing drug use. In: Human Rights Watch [website]. 12 October 2016. New York: Human Rights Watch; c2019 (https://www.hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states#, accessed 8 February 2019).

8. Kontautaite A, Matyushina-Ocheret D, Plotko M, Golichenko M, Kalvet M, Antonova L. Study of human rights violations faced by women who use drugs in Estonia. Harm Reduct J. 2018;15(1):54.

9. European Monitoring Centre for Drugs and Drug Addiction. Portugal: country drug report 2017. Luxembourg: Publications Office of the European Union; 2017.

10. Hughes CE, Stevens A. The effects of the decriminalization of drug use in Portugal. Oxford: The Beckley Foundation; 2007 (https://core.ac.uk/download/pdf/91904.pdf, accessed 5 March 2019).

11. A new approach to managing illegal psychoactive substances in Canada. Ottawa; Canadian Public Health Association; 2014 (https://www.cpha.ca/sites/default/files/assets/policy/ips_2014-05-15_e.pdf, accessed 4 March 2019).

12. Committee on Economic, Social and Cultural Rights. Concluding observations on the combined fifth and sixth periodic reports of the Philippines. 26 October 2016 (E/C.12/PHL/CO/5-6).

13. Report to the General Assembly. UN Special Rapporteur on health, Anand Grover. In: Sixty-fifth session, New York, 6 August 2010 (A/65/255; https://undocs.org/en/A/65/255, accessed 3 March 2019).

14. Office of the United Nations High Commissioner for Human Rights. Implementation of the joint commitment to effectively addressing and countering the world drug problem with regard to human rights. 14 September 2018 (A/HRC/39/39; https://undocs.org/A/HRC/39/39, accessed 3 March 2019).

15. UNAIDS, UNHCR, UNICEF, WFP, UNDP, UNFPA et al. Joint United Nations statement on ending discrimination in health care settings. 2017 (http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf, accessed 4 March 2019).

16. Measures to reduce pretrial detention. IACHR, OAS; 2017 (http://www.oas.org/en/iachr/reports/pdfs/pretrialdetention.pdf, accessed 4 March 2019).

17. African Commission on Human and Peoples' Rights. HIV, the law and human rights in the African human rights system: key challenges and opportunities for a rights-based system. Banjul (The Gambia): African Union; 2018 (http://www.unaids.org/en/resources/documents/2018/HIV_Law_AfricanHumanRightsSystem, accessed 4 March 2019).

18. Global State of harm reduction 2018. London: Harm Reduction International; 2018 (https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf, accessed 4 March 2019).

19. The Human Toll of Georgia's Abusive Drug Policies. In: Human Rights Watch [website]. 13 August 2018. New York: Human Rights Watch; c2019 (https://www.hrw.org/report/2018/08/13/harsh-punishment/human-toll-georgias-abusive-drug-policies#, accessed 5 March 2019).

20. Taking stock: a decade of drug policy—a civil society shadow report. London (UK): International Drug Policy Consortium (IDPC); 2018 (https://idpc.net/publications/2018/10/taking-stock-a-decade-of-drug-policy-a-civil-society-shadow-report, accessed 18 February 2019).

21. Canada becomes second country legalise Cannabis. In: The Guardian [UK]. 17 October 2018. Guardian News and Media Limited; c2019 (https://www.theguardian.com/world/2018/oct/17/cannabis-becomes-legal-in-canada-marijuana, accessed 4 March 2019).

22. The drug killings: who, what, where, when, how? In: The Drug Archive. Ateneo School of Government at Ateneo de Manila University (https://drugarchive.ph/post/26-the-drug-killings-who-what-where-when-how-master, accessed 31 January 2019).

23. Philippines' "War on Drugs." In: Human Rights Watch [website]. New York: Human Rights Watch; c2019 (https://www.hrw.org/tag/philippines-war-drugs, accessed 4 March 2019).

24. "If you are poor, you are killed." Extrajudicial executions in the Philippines' "War on Drugs." London: Amnesty International; 2017 (https://www.amnestyusa.org/files/philippines_ejk_report_v19_final_0.pdf, accessed 4 March 2019).

25. Joint Statement on the Human Rights Situation in the Philippines. In: Thirty-eighth session, Human Rights Council, New York, 19 June 2018 (https://dfat.gov.au/international-relations/international-organisations/un/unhrc-2018-2020/statements/Documents/38th-hrc-joint-statement-human-rights-situation-philippines.pdf, accessed 4 March 2019).

26. Judy Chang, International Network of People Who Use Drugs. Personal communication. 28 January 2019.

27. United Nations Human Rights Committee. General comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the right to life. 30 October 2018 (https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/1_Global/CCPR_C_GC_36_8785_E.pdf, accessed 4 March 2019).

28. Statement by Dr Lochan Naidoo, President, International Narcotics Control Board. In: Fifty-eighth session of the Commission on Narcotic Drugs. Special segment on preparations for the special session of the General Assembly on the world drug problem (UNGASS) to be held in 2016 Vienna, 9–17 March 2015 (https://www.incb.org/documents/Speeches/Speeches2015/Statement_INCB_President_CND_2015_UNGASS_06_03_15V_1_cl_INCB_logo.pdf, accessed 4 March 2019).

29. The death penalty for drug offences: global overview 2018. London: Harm Reduction International; 2019.

30. Mayberry K. Malaysia says no 'U-turn' in death penalty abolition. In: Aljazeera [website]. 16 November 2018 (https://www.aljazeera.com/news/2018/11/malaysia-turn-death-penalty-abolition-181115061626577.html, accessed 4 March 2019).

31. Human Rights Council Resolution 12/27. The protection of human rights in the context of immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (A/HRC/RES/12/27). 22 October 2009.

32. Harm Reduction Coalition calls for removal of legal barriers in response to successful trial of an unsanctioned supervised injection facility in US. In: Harm Reduction Coalition [website]. 8 August 2017. New York and Oakland; Harm Reduction Coalition (https://harmreduction.org/blog/unsanctioned-supervised-injection-facility-in-us/, accessed 4 March 2019).

33. Report of the United Nations High Commissioner for Human Rights. Study on the impact of the world drug problem on the enjoyment of human rights. In: Thirtieth session of the Human Rights Council, New York, 4 September 2015 (A/HRC/30/65; https://undocs.org/en/A/HRC/30/65, accessed 3 March 2019).

34. Committee on the Elimination of Discrimination against Women. Concluding observations on the combined eighth and ninth periodic reports of Canada. 25 November 2016 (CEDAW/C/CAN/CO/8-9; https://undocs.org/en/CEDAW/C/CAN/CO/8-9, accessed 3 March 2019).

35. Police statement of support for drug policy reform. Centre for Law Enforcement and Public Health, Law Enforcement Action Partnership; 2019 (https://cleph.com.au/application/files/4815/4957/9983/Statement_of_Support_for_Drug_Policy_Reform_Feb_2019.pdf, accessed 4 March 2019).

36. Krisanaphong Poothakool, Royal Police Cadet Academy Thailand. Personal communication. 9 February 2019.

37. Jones Blantari, Ghana Police. Personal communication. 4 February 2019.

38. UNAIDS, ILO, OHCHR, UNDP, UNESCO, UNFPA et al. Joint statement: compulsory drug detention and rehabilitation centres. 2012 (http://files.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf, accessed 26 February 2019).

39. International Narcotics Control Board report 2016. Vienna: International Narcotics Control Board; 2016.

40. Garmaise D. Global Fund to end funding for HIV services in drug treatment centers in Viet Nam. Global Fund Observer Newsletter 234. 6 January 2014 (http://www.aidspan.org/gfo_article/global-fund-end-funding-hiv-services-drug-treatment-centres-viet-nam, accessed 4 March 2019).

41. Report of the UN Working Group on Arbitrary Detention on its visit to the United States of America. In: Thirty-sixth session, Human Rights Council, 17 July 2017 (UN Doc. A/HRC/36/37/Add.2).

42. Report of the Working Group on the issue of discrimination against women in law and in practice. In: Thirty-second session, Human Rights Council, 8 April 2016 (UN Doc. A/HRC/32/44).

43. Csete J, Pearshouse R. Detention and punishment in the name of drug treatment. New York: Open Society Foundations; 2016 (https://www.opensocietyfoundations.org/sites/default/files/detention-and-punishment-name-drug-treatment-20160315.pdf, accessed 4 March 2019).

44. Lunzea K, Lermetb O, Andreevac V, Harigad F. Compulsory treatment of drug use in Southeast Asian countries. Int J Drug Pol. 2018;59:10–5.

45. Calabrese SK, Burke SE, Dovidio JF, Levina OS, Uusküla A, Niccolai LM. Internalized HIV and drug stigmas: interacting forces threatening health status and health service utilization among people with HIV who inject drugs in St. Petersburg, Russia. AIDS Behav. 2016;20(1):85–97.

46. Measuring HIV-related stigma and discrimination in health care settings in Thailand. Report of a pilot: developing tools and methods to measure HIV-related stigma and discrimination in health care settings in Thailand. International Health Policy Program, Ministry of Public Health, Thailand; 2014.

47. Briefing paper: sex workers who use drugs. Experiences, perspectives, needs and rights: ensuring a joint approach. Global Network of Sex Work Projects, International Network of People Who Use Drugs; 2015 (https://www.inpud.net/sex_workers_who_use_drugs_nswp_inpud_oct_2015.pdf).

48. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. New York: United Nations General Assembly; 2016.

49. Global partnership for action to eliminate all forms of HIV-related stigma and discrimination. Geneva: UNAIDS; 2018 (http://www.unaids.org/en/resources/documents/2018/global-partnership-hiv-stigma-discrimination, accessed 4 March 2019).

50. Guidance note. Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses. Geneva: UNAIDS; 2012 (http://www.unaids.org/sites/default/files/sub_landing/files/Key_Human_Rights_Programmes_en_May2012_0.pdf, accessed 4 March 2019).

51. UN Human Rights Council Resolution 37/42. Contribution to the implementation of the joint commitment to effectively addressing and countering the world drug problem with regard to human rights (A/HRC/RES/37/42). 23 March 2018.

52. Supporting the implementation of the international drug control policy through effective inter-agency collaboration. In: Second regular session of 2018, Chief Executives Board for Coordination, 7–8 November 2018, Annex I (CEB/2018/2).

53. International Guidelines on Human Rights and Drug Policy. New York: United Nations Development Programme, the International Centre for Human Rights and Drug Policy; 2019.

54. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2016.

55. Council conclusions on promoting the use of alternatives to coercive sanctions for drug using offenders. Council of the European Union; 2018 (http://www.emcdda.europa.eu/document-library/council-conclusions-promoting-use-alternatives-coercive-sanctions-drug-using-offenders_en, accessed 4 March 2019).

56. Model drug law for West Africa. A tool for policy-makers. West Africa Commission for Drugs; 2018 (https://www.globalcommissionondrugs.org/wp-content/uploads/2018/08/WADC-MDL-EN-WEB.pdf, accessed 4 March 2019).

57. New model drug law launched in Western Africa. In: UNAIDS [website]. 12 September 2018. Geneva: UNAIDS; c2019 (http://www.unaids.org/en/resources/presscentre/featurestories/2018/september/new-model-drug-law-launched-in-western-africa, accessed 5 March 2019).

58. Jamie Bridge, International Drug Policy Consortium. Personal communication. 17 January 2019.

59. World Drug Report 2018. Vienna: UNODC; 2018.

60. Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs: consolidated guidelines. Geneva: WHO; 2016.

61. Committee on Economic, Social and Cultural Rights. Concluding observations on the fifth periodic report of Australia (C.12/AUS/CO/5). 11 July 2017.

62. Communication from Philip Alston, UN Special Rapporteur on extreme poverty and human rights. 17 October 2017 (AUS 5/2017).

63. Social protection: a Fast-Track commitment to end AIDS. Guidance for policy-makers and people living with, at risk of or affected by AIDS. Geneva: UNAIDS; 2018 (http://www.unaids.org/en/resources/documents/2018/social-protection-fast-track-commitment-end-aids, accessed 4 March 2019).

64. Support Fund for HIV/AIDS Patients and their Families. In: Social Welfare Department [website]. Social Welfare Department: The Government of the Hong Kong Special Administrative Region; c2005 (https://www.swd.gov.hk/en/index/site_pubsvc/page_medical/sub_supportfun/, accessed 4 March 2019).

65. Domoslawski A. Drug policy in Portugal: the benefits of decriminalizing drug use. In: Open Society Foundations [website]. August 2011. Open Society Foundations; c2019 (https://www.opensocietyfoundations.org/reports/drug-policy-portugal-benefits-decriminalizing-drug-use, accessed 4 March 2019).

66. LEAD: National Support Bureau [website]. Seattle; LEAD (https://www.leadbureau.org/, accessed 4 March 2019).

67. Collins SE, Lonczak HS, Clifasefi SL. Seattle's Law Enforcement Assisted Diversion (LEAD): program effects on recidivism outcomes. Eval Program Plann. 2017;64:49–56.

68. Clifaseli SL, Lonczak HS, Collins SE. Seattle's Law Enforcement Assisted Diversion (LEAD) program: within-subjects changes on housing, employment, and income/benefits outcomes and associations with recidivism. Crime & Deliquency. 2017;1–17.

4. THE ROLE OF COMMUNITIES

1. Local actions, global voice: the Support Don't Punish day of action on 26th June 2016. In: Community Action on Harm Reduction [website]. 21 June 2016 (http://www.cahrproject.org/news/local-actions-global-voice-the-support-dont-punish-day-of-action-on-26th-june-2016/, accessed 4 March 2019).

2. momsunited to end the war on drugs [website] (https://www.momsunited.net/listentomom accessed 5 March 2019).

3. Ukrainian national conference on drug policy. In: EU-ACT [website]. EU-ACT; c2017 (https://eu-act.info/en/news/ukrainian-national-conference-on-drug-policy?fbclid=IwAR3c02DJK7pqHNBs20G9kz3u5debNi62RG11_ZH-tmKjKotlzm84DHnyXao, accessed 4 March 2019).

4. Moldova is preparing for a visit to Portugal [in Russian]. In: EACB [website]. 17 May 2018 (https://harmreductioneurasia.org/ru/moldova-gotovitsya-k-portugalii/?fbclid=IwAR0FAKUY4Rh1tdEVnENf6oAuPoOS2woMPhbYWnsGB-F3RywNmN840CesHcc, accessed 4 March 2019).

5. See for example: Russian Public Mechanism for Monitoring of Drug Policy Reform, Shadow Report to the Committee on Economic, Social and Cultural Rights in relation to the review of the 6th Periodic Report of the Russian Federation (E/C.12/RUS/6). January 2017.

6. See for example: Committee on Economic, Social and Cultural Rights Concluding Observations on the sixth periodic report of the Russian Federation 16 October 2017 (E/C.12/RUS/CO/6).

7. Aaraj E, Jreij Abou Chrouch M. Drug policy and harm reduction in the Middle East and North Africa: the role of civil society. Int J Drug Policy. 2016;31:168–71.

8. Maistat L, Kravchenko N, Reddy A. Hepatitis C in Eastern Europe and Central Asia: a survey of epidemiology, treatment access and civil society activity in eleven countries. Hepatol Med Policy. 2017;2:9.

9. Drug Policy Impact Assessment for Change in Central and Eastern Europe [website] (available at http://galiugyventi.lt/drug-policy-impact-assessment-for-change-in-central-and-eastern-europe/ accessed 5 March 2019).

10. Committee on Economic, Social and Cultural Rights. Concluding observations on the combined fifth and sixth periodic reports of the Philippines. 26 October 2016 (E/C.12/PHL/CO/5-6).

11. Committee on Economic, Social and Cultural Rights. Concluding observations on the combined second to fourth periodic reports of the former Yugoslav Republic of Macedonia. 15 July 2016 (E/C.12/MKD/CO/2-4).

12. Canadian HIV/AIDS Legal Network, International Centre on Human Rights and Drug Policy. Canada: Drug Policy And Economic, Social, And Cultural Rights — Submission To The Committee On Economic, Social and Cultural Rights. 2 February 2016.

13. Committee on Economic, Social and Cultural Rights. Concluding observations on the sixth periodic report of Canada. 23 March 2016 (E/C.12/CAN/CO/6).

14. Committee on the Elimination of Discrimination against Women. Concluding observations on the combined eighth and ninth periodic reports of Canada. 25 November 2016 (CEDAW/C/CAN/CO/8-9).

15. Committee on the Elimination of Racial Discrimination. Concluding observations on the combined twenty-first to twenty-third periodic reports of Canada. 13 September 2017 (CERD/C/CAN/CO/21–23).

16. Amnesty International movement adopts new policy positions on abortion and drug control. In: Amnesty International [website]. 9 July 2018. Amnesty International; c2019 (https://www.amnesty.org/en/latest/news/2018/07/amnesty-international-adopts-abortion-and-drug-control-stance/, accessed 4 March 2019).

17. NGO reporting guidelines on CEDAW and rights of women who use drugs. Kuala Lumpur: IWRAW Asia Pacific; 2018 (https://www.iwraw-ap.org/resources/ngo-reporting-guidelines-on-cedaw-rights-of-women-who-use-drugs/, accessed 4 March 2019).

18. Fischler F. Why drug policy is a feminist issue. In: AWID [website]. 14 November 2018. AWID; c2018 (https://www.awid.org/news-and-analysis/why-drug-policy-feminist-issue, accessed 4 March 2019).

19. Nonprofits working with vulnerable groups. In: E.V.A. [website]. E.V.A.; c2010–2017 (https://evanetwork.ru/en/project/nonprofits-working-with-vulnerable-groups/, accessed 4 March 2019).

20. St Petersburg administration supports social NGOs. In: The BEARR Trust [website]. London: The BEARR Trust; c2019 (http://www.bearr.org/st-petersburg-administration-supports-social-ngos/, accessed 4 March 2019).

21. Resolution 70/266. Political Declaration on HIV and AIDS: on the Fast–Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. In: Seventieth session, New York, 22 June 2016 (A/RES/70/266; http://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf, accessed 18 February 2019).

22. 2017–2022 strategic key performance indicator framework. GF/B35/07a - Revision1. Board decision. 26–27 April 2016, Abidjan, Côte d'Ivoire. The Global Fund; 2016 (https://www.theglobalfund.org/media/4230/bm35_07a-2017-2022keyperformanceindicatorframeworknarrative_report_en.pdf?u=636488964120000000; accessed 28 February 2019).

23. Peter Sarosi, European Union Civil Society Forum on Drugs. Personal communication. 10 January 2019.

24. Varentsov A. As funding from the Global Fund is phased out, Bulgaria struggles to find sustainable financing. In: aidspan.org [website]. 19 September 2017. Aidspan; c2002–2017 (http://www.aidspan.org/ru/node/4344, accessed 4 March 2019).

25. Budget advocacy: a guide for community activists. Vilnius (Lithuania): Eurasian Harm Reduction Association; 2018.

26. Oxana Ibragimova, Eurasian Harm Reduction Network. Personal communication. 1 February 2019.

27. Social contracting: working towards sustainable responses to HIV, TB and malaria through government financing of programs implemented by civil society. APMG Health; 2017 (https://apmghealth.com/sites/apmghealth.com/files/projects/docs/global_consultation_on_social_contracting-_background_paper.pdf, accessed 4 March 2019).

28. Power L. Civil society under threat: how can HIV advocates resist the impact? In: aidsmap.com [website]. 26 July 2018. London: NAM publications; c2019 (http://www.aidsmap.com/Civil-society-under-threat-How-can-HIV-advocates-resist-the-impact/page/3314276/, accessed 4 March 2019).

29. Civil society under threat – experience from Russia. In: Andrey Rylkov Foundation for Health Justice [website]. 5 August 2018 (http://en.rylkov-fond.org/blog/voices-from-russia/aids-2018/, 4 March 2019).

30. Russian HIV prevention group closes after fine under "Foreign-Agent" law. In: Radio Free Europe/Radio Liberty [website]. 4 December 2018. Radio Free Europe/Radio Liberty; c2019 (https://www.rferl.org/a/russian-hiv-prevention-group-closes-after-fine-under-foreign-agent-law/29636884.html, accessed 4 March 2019).

31. Plavinskiy (Плавинский). Presentation at the EECAAC 2018 (available at http://www.eecaac2018.org/eecaac/summary/).

32. Information Bulletin (http://www.hiv-spb.ru/inf-bulletin-6-2017.pdf, accessed 5 July 2018).

33. Gusev D. Modern aspects of counteracting the spread of HIV infection in St. Petersburg (http://congress-ph.ru/common/htdocs/upload/fm/ vich/17/october/prez/5-K-02.pdf, accessed 5 July 2018).

34. Sergeg Dugin, Director, Humanitarian Action. Personal communication. 16 January 2019.

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