



GLOBAL  
COMMISSION ON  
DRUG POLICY

REPORT

# HIV, HEPATITIS & DRUG POLICY REFORM





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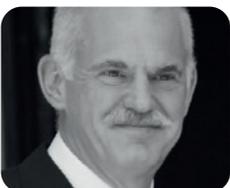
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# HIV, HEPATITIS & DRUG POLICY REFORM

2023 REPORT

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# FOREWORD

With the aim of opening an honest debate on drugs and of inspiring better policies globally, political leaders, cultural figures, and globally influential personalities established the Global Commission on Drug Policy in 2011. Today, all of its twenty-nine members, in their individual capacities, highlight the negative impact of the current international drug control regime on health, human rights, and development and call for abandoning the prohibitionist approach.

Although many countries are embracing harm reduction, decriminalisation, and cannabis regulation, the three International Drug Control Conventions of the United Nations continue to be problematic for governments wishing to adopt evidence- and rights- based policies. Science and human rights need to inform drug policy deliberations and guide the adoption of policies and practices which maximise the public good.

The Global Commission has built a strong body of evidence and recommendations to provide guidance – particularly to policy makers – on how to develop and implement better laws and policies. It recommends that drug policy reform follow five pathways: 1). Putting people’s health and safety first; 2). Ensuring access to essential medicines and pain control; 3). Ending the criminalization and incarceration of people who use drugs; 4). Refocusing enforcement responses to drug trafficking and organized crime; and 5). Regulating drug markets to put governments in control.

This report, “HIV, Hepatitis and Drug Policy Reform” follows on from the Global Commission’s thematic reports on “The War on Drugs and HIV/AIDS” (2012) and “The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic” (2013). In 2023, approximately 354 million people around the world are currently living with hepatitis B or C – that is more than the current population of the United States of America. People who use drugs, especially people who inject drugs, are at a higher risk for blood-borne HIV, hepatitis B and hepatitis C. Although there has been some success – for example, the scale-up of antiretroviral treatments that reduced HIV related deaths to their lowest in almost three decades – progress has been uneven and people who use drugs are still left behind. This must change.

This report provides an overview of the global status of HIV and hepatitis, and proposes recommendations for action that respect, protect, and fulfill the human rights and health of people who use drugs. The recent report of the Office of the UN High Commissioner for Human Rights (A/HRC/54/53) highlights how human rights are indeed prerequisites in all drug policies and practices – and they are essential to ending HIV and hepatitis among people who use drugs.

To deliver a drug policy fit for the twenty-first century, national legal frameworks must be in accordance with human rights norms and based on evidence. With this in mind, we must maintain steady progress on decriminalization, scale up the provision of harm reduction services, and provide more and better access to controlled medicines.

The case for drug policy reform is clear: the current international drug control system has failed. There are terrible consequences from prohibitionist and draconian drug laws around the world’s regions. There must be change. We can save lives, and ultimately end HIV and hepatitis as public health threats and as threats to people who use drugs.



Rt Hon **Helen Clark**  
Chair of the Global Commission on Drug Policy



*Youth sensitization on PrEP (pre-exposure prophylaxis) and self-testing in Man, western Côte d'Ivoire.*  
© UNICEF / Diarassouba

## Acronyms

**ARV** antiretroviral  
**HBV** hepatitis B  
**HCV** hepatitis C  
**HDV** hepatitis D

**NSP** needle-syringe program  
**OAT** opioid agonist treatment  
**PWID** people who inject drugs  
**PrEP** pre-exposure prophylaxis

# INTRODUCTION

The prohibition and criminalization of drug use and possession continue to fuel the global HIV and viral hepatitis epidemics – sharply increasing risks for people who use drugs, obstructing efforts to prevent new transmissions, and hindering treatment. Proven harm reduction interventions are scarcely resourced, while billions are spent to enforce punitive drug laws and policies. People who use drugs are routinely caught up in the criminal justice system, frequently remain the target of abusive policing practices, and are incarcerated at massively disproportionate levels – all of which further increase their risks for HIV and viral hepatitis. Meanwhile, stigma and discrimination created and perpetuated by criminalization drive people to use drugs in increasingly dangerous settings and impede their ability to use drugs safely. At the same time, people who use drugs face prohibition- and law enforcement-related barriers to accessing services within and beyond the health sector.

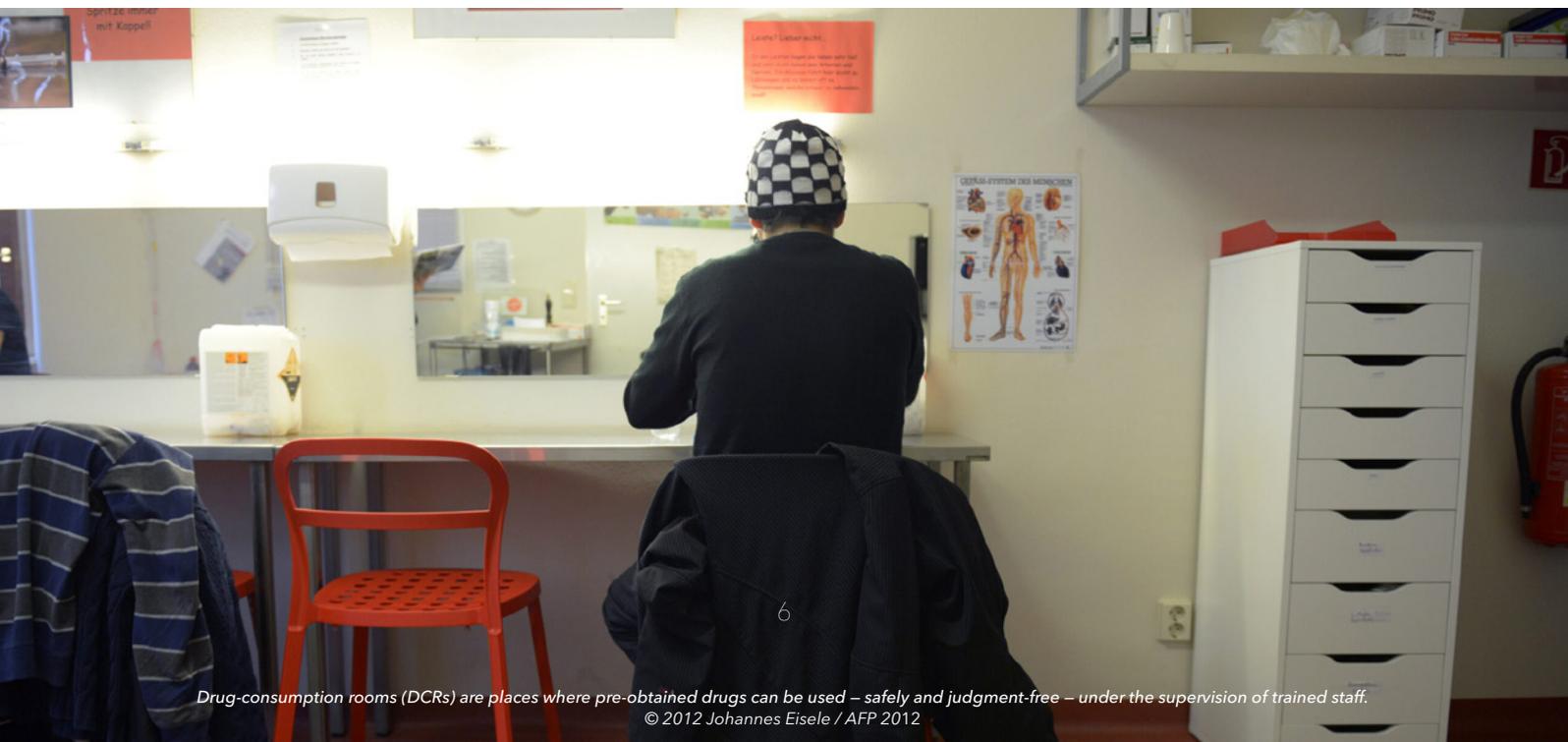
Even on its own terms, prohibition is a failure. As the Global Commission on Drug Policy noted more than a decade ago, current drug control efforts have failed to reduce drug use or supply, or to reduce the risks for HIV and viral hepatitis among people who use drugs. While people who inject drugs are at particular risk, there has been no appreciable decline either in the prevalence of injecting drug use, nor in HIV, hepatitis C (HCV) or hepatitis B (HBV) prevalence among people who inject drugs.

People who use drugs have been left behind. Among people who inject drugs, one in seven is living with HIV, one in five is living with chronic HCV and one in 12 is living with chronic HBV.

None of this has to be the case. Globally, the end of the HIV and viral hepatitis epidemics is within grasp. Aligned with the Sustainable Development Goals, the UN has set achievable targets for ending HIV and eliminating viral hepatitis as a public health threat by 2030. The scale-up of antiretroviral treatments for HIV over the past 20 years has been a dramatic success, reducing HIV-related deaths to their lowest in almost three decades. And yet... because of denial or willful neglect, many countries have failed to address epidemics among people who use drugs.

A course correction is greatly needed. Effectively addressing HIV and viral hepatitis among people who use drugs could end both epidemics. On the other hand, the continued failure to systematically confront HIV and viral hepatitis among people who use drugs will thwart global efforts.

We have the knowledge and the means. But such a shift will require political will – and for governments and societies to embrace a new way of thinking about drugs. It has been more than a decade since the Global Commission called on the international community to act urgently to avert the significant public health harms that result from HIV and viral hepatitis. We need a new path forward. The time to act is now.



*Drug-consumption rooms (DCRs) are places where pre-obtained drugs can be used – safely and judgment-free – under the supervision of trained staff.*

## HIV

In 2020, there were **37 700 000** people living with HIV and **1 500 000** new HIV infections, while **680 000** people died from HIV-related causes.

The scale-up of effective antiretroviral (ARV) treatments has been a game changer, reducing HIV-related deaths by 52% between 2010 and 2022. Current WHO “Treat All” guidelines call for the rapid (ideally same-day) initiation of ARV medicines, resulting in viral suppression – which in turn reduces the risk of onward HIV transmission to zero.<sup>1</sup> Today, 93% of people living with HIV who are aware of their status and taking ARV treatment as prescribed are not at risk of transmitting HIV sexually.

ARV treatments are also effective for primary HIV prevention. Pre-exposure prophylaxis (PrEP) is highly protective for sexual HIV transmission. Evidence is more limited for the prevention of bloodborne (i.e., parenteral) HIV infection, in part because people who inject drugs have been excluded from most PrEP research trials.<sup>2,3</sup>

UN targets call for 95% of all people living with HIV to know their HIV status, 95% of all people with diagnosed HIV infection to receive sustained ARV treatment, and 95% of all people receiving ARV treatment to have viral suppression by 2025. Globally, progress has been impressive – in 2022, 86% of people living with HIV knew their HIV status, 76% were receiving ARV treatments, and 71% were virally suppressed. There have also been dramatic reductions in new HIV infections.

Progress has been disappointing among people who inject drugs, however, primarily due to a lack of prevention services and barriers imposed by punitive laws, violence, stigma, and discrimination. In 2022, HIV prevalence was seven times higher among people who inject drugs than among all adults.

Among people living with HIV, coinfection with tuberculosis remains a significant concern, especially among people who inject drugs. While improvements in the integration of HIV and tuberculosis services have led to a steep drop in mortality, tuberculosis remains the leading cause of death among people living with HIV.

## Hepatitis C

In 2019, there were **58 000 000** people living with chronic HCV and **1 500 000** new HCV infections, while **290 000** people died from HCV-related causes.

Hepatitis C is an inflammation of the liver caused by the hepatitis C virus (HCV). It can cause both acute (short-term) infections, which are usually asymptomatic, and chronic (long-term) illness, which can be fatal. Like HIV, HCV is spread through sharing needles or syringes, unsafe medical procedures or blood transfusions, or via practices such as nonsterile tattooing. HCV is considerably more infectious than HIV, though less infectious than hepatitis B (HBV). Compared to all adults, HCV is much more common among people who inject drugs.

Among people who inject drugs, 25% of acute HCV infections clear spontaneously without any treatment.<sup>4,5</sup> The remaining 75% will develop chronic HCV infection, where the risk of cirrhosis ranges from 15% to 30% within 20 years. WHO recommends that people who inject drugs have access to testing for HCV (along with HIV and HBV), with linkages to prevention, care and treatment – early diagnosis can prevent health problems and onward HCV transmission.

Because it is usually asymptomatic, acute HCV infection often goes undiagnosed, while chronic HCV is often not diagnosed until symptoms (often related to liver damage) appear decades after infection.

There is no HCV vaccine, but most people can be cured with direct-acting antiviral medications. Treatment is always needed for chronic HCV infection – with proper treatment, many people can be cured and live healthy lives, and also prevent further onward transmission. Reinfection is possible after a previous infection is resolved without treatment or cured with medication, however, underscoring the need for harm reduction.

Prices for direct-acting antivirals have dropped dramatically due to the availability of generic medications – in many countries, a treatment course costs <US\$50. Current direct-acting antivirals require minimal provider expertise or monitoring and can be administered by trained non-specialist doctors and nurses, in primary care, harm reduction services, or prisons. There have also been major price reductions in hepatitis diagnostics, though patent barriers persist in middle-income countries.

Improved access to HCV diagnostics and treatment has for the first time reversed what had been an increasing trend in HCV-related deaths – as of 2021, 9.4 million people were receiving treatment to cure chronic HCV infection, an almost 10-fold increase from 2015. Yet there is still far to go – reaching targets for HCV elimination by 2030 would require a nearly sixfold increase in treatment coverage.<sup>6</sup>

## Hepatitis B

In 2019, there were **296 000 000** people living with chronic HBV and **1 500 000** new HBV infections, while **820 000** people died from HBV-related causes.

Hepatitis B is an infection of the liver caused by the hepatitis B virus (HBV), which can also be acute or chronic. In adults, only 5% of those with acute HBV infection progress to chronic disease – which carries a high risk of death from cirrhosis and/or liver cancer. Chronic HBV infection can be treated with a variety of medicines, with the goal of slowing disease progression and improving survival, though lifelong treatment is often required.

HBV is considerably more infectious than HIV or HCV – and can also be transmitted sexually or through sharing needles or syringes. WHO recommends HIV, HCV and HBV testing for people who inject drugs.

HBV infection can be prevented with a highly effective vaccine, which is generally administered to infants. Because they may not have received a childhood HBV vaccine, WHO recommends that catch-up HBV vaccinations be offered to all people who inject drugs.

Globally, only 10% of people with chronic HBV infection are diagnosed, 22% of whom receive treatment. About one percent (1%) of people living with HBV infection are also living with HIV, while among people living with HIV, 7% are also HBV-infected. WHO recommends treatment for everyone co-diagnosed with HIV and HBV infection.

## Hepatitis D

Hepatitis D is an inflammation of the liver caused by the hepatitis D virus (HDV), which only occurs in people with HBV infection – globally, nearly five percent (5%) of people with chronic HBV infection are co-infected with HDV. Like HBV and HCV, HDV infection can be transmitted through sharing needles or syringes, and people who inject drugs are at higher risk for coinfection.

HDV infection occurs when people become infected with both HBV and HDV simultaneously (coinfection) or acquire HDV after first being infected with HBV (super-infection). Among people who experience simultaneous coinfection, recovery is usually complete and chronic HDV infection is rare (<5%). In a super-infection, however, HDV accelerates the progression of chronic HBV infection to severe liver disease in 70-90% of people.

# THE DRUG POLICY AND HIV AND VIRAL HEPATITIS NEXUS: THE IMPACT OF CRIMINALIZATION

Prohibition has criminalized drug use, drug possession and, effectively, people who use drugs, which increases their risk for HIV and viral hepatitis. Most countries have laws or policies prohibiting drug use and possession, which create barriers to effective HIV, viral hepatitis and other health services for people who use drugs. In a 2017 systematic review, the criminalization of drug use – i.e., incarceration, street-level policing, drug paraphernalia laws, prohibitions or restrictions on harm reduction, and national drug strategies – was associated with decreased syringe distribution, increased syringe sharing, and higher HIV prevalence among people who inject drugs.<sup>7</sup>

For people who use drugs, criminalization is associated with poorer health outcomes. In a recent study, in countries that criminalize drug use, the proportion of people who inject drugs (PWID) who were living with HIV and knew their status was 14.2% lower, while the proportion with viral suppression was 14.5% lower, compared to countries where drug use was not criminalized. Conversely, in countries with anti-discrimination laws, human rights institutions, and responses to gender-based violence, the proportion who knew their status and/or with viral suppression was higher.<sup>8</sup>

Involvement with the criminal justice system directly increases the risk for HIV and viral hepatitis. Incarceration is associated with substantial increases in the risk for HIV and hepatitis C (HCV) infection among PWID.<sup>9</sup> Criminalization also leads to abusive policing practices, perpetuating a culture of fear among people who use drugs and further increasing their risk for HIV or viral hepatitis. For example, PWID often avoid harm reduction programs due to a fear of police harassment, syringe confiscation, arrest, demands for bribes, or threats of violence/torture. Police detentions can also interrupt adherence to opioid agonist treatment (OAT) or antiretroviral (ARV) treatment.<sup>10</sup>

The impact of criminalization is even more pronounced among populations for whom stigma and discrimination already impose barriers to HIV or viral hepatitis services. The enforcement of drug laws is often discriminatory, disproportionately targeting subpopulations (particularly minorities and other criminalized subpopulations, such as sex workers or gay men) already at elevated risk for HIV and viral hepatitis as a result of punitive laws, stigma or discrimination.

Criminalization impedes the scale-up of proven harm reduction programs and constrains how they are delivered. Laws and policies criminalizing drug use, possession, or paraphernalia are often used as an excuse to prohibit or constrain effective harm reduction interventions, such as needle-syringe programs (NSP). Punitive laws also impede utilization of programs that do exist. For example, in some instances PWID are arrested for possession of drug paraphernalia while enroute to/from lawful NSP.<sup>11</sup>

For people who use drugs, punitive laws and policies create barriers to health services. Criminalization often interferes with the provision of effective HIV/viral hepatitis prevention, testing, diagnosis, or treatment. People who use drugs are often stigmatized in healthcare settings and may avoid seeking needed care or services, ironically including OAT and housing, both of which have been shown to reduce HIV and HCV incidence.<sup>12-15</sup> Cessation of drug use, though medically unwarranted, is sometimes a condition for eligibility for ARV treatment for HIV, direct-acting antiviral treatment for HCV, OAT for drug dependence, or in some instances, housing.

Beyond legal sanctions, criminalization renders people who use drugs susceptible to a range of discrimination and other human rights violations and abuses. Criminalization reflects but also excuses and exacerbates societal stigma and discrimination. As a result, people who use drugs are often excluded

from programs that might otherwise help in improving or maintaining their health and stability, including public housing, welfare or food aid, education, job training or employment.

Administrative or civil sanctions imposed in lieu of criminal sanctions often amount to significant punishment. In many countries, particularly in Asia, people who use or possess drugs can be remanded to compulsory detention or rehabilitation, sometimes in the community, but often in a closed facility. In some countries, drug use or possession establishes a legal basis for removing children from parental

custody. Even administrative fines can be onerous, potentially leading to a spiral of debt.

Some countries continue to impose the death penalty for drug-related offenses, despite the clear violation of international human rights law. Such offenses do not meet the threshold of 'most serious' crimes to which the death penalty can be applied. As of 2022, according to Harm Reduction International (HRI), 35 countries maintained the death penalty for drug-related offenses, and there were 285 executions, confirmed or assumed to have happened in Iran, Saudi Arabia, and Singapore.<sup>16</sup>





# HIV AND VIRAL HEPATITIS AMONG PEOPLE WHO USE DRUGS

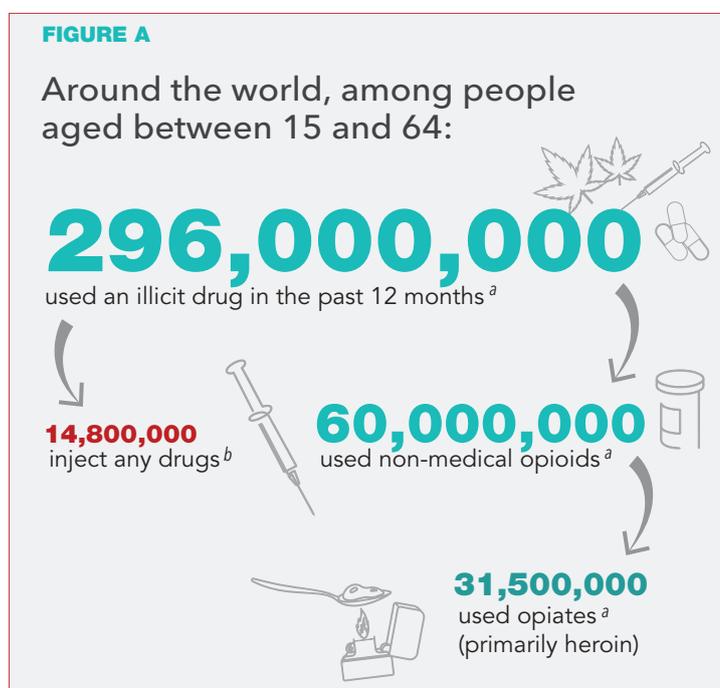
## The prevalence of drug use, injection drug use, and HIV and viral hepatitis among people who inject drugs

Despite decades of prohibition, the use of drugs is common across the globe. Prohibition is a failure. Prohibition and the criminalization of drugs, drug use and possession have neither reduced the supply of drugs, which remain abundant, nor reduced the numbers of people who use drugs, which continues to grow. An estimated 296 million people (6% of the global population between the ages of 15-64) used an illicit drug in the past 12 months. Of those, an estimated 60 million used non-medical opioids, and of those, 31.5 million used opiates\* (primarily heroin).<sup>17</sup> (see figure A)

While the prevalence of injection drug use is relatively low, there is considerable risk for HIV or viral hepatitis associated with the use of non-sterile injection equipment. Globally, an estimated 14.8 million people inject drugs (0.3% of the global population ages 15-64). The prevalence of injection drug use is highest in eastern Europe (1%) and North America (1.4%), which is home to the highest absolute number (3.3 million) of PWID (see figure A). While people sometimes inject more than one drug, opioids are the main drug injected for 83% of PWID. Non-opioid drugs such as stimulants are less commonly the main drug injected, accounting for 20% of PWID.<sup>18</sup>

The risks for HIV and viral hepatitis are much higher among people who inject drugs. There is a high risk for blood-borne infections from using non-sterile injection equipment (i.e., needles, syringes, filters, cotton, cookers), while the availability of sterile equipment is frequently lacking. For PWID, the risk for acquiring HIV is 35 times higher than for those who do not inject drugs. Nine percent (9%) of all new HIV infections and 23% of all new HCV infections occur among PWID.<sup>17</sup>

\* The term *opioids* refers both to *opiates* (a subset of compounds derived from the opium poppy, such as heroin) and their synthetic analogues, as well as compounds synthesized in the body.



**Data sources:** a. UNODC. World Drug Report 2023 (executive summary). Vienna; 2023.  
b. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *Lancet Glob Health*. 2023

In the absence of sterile injection equipment, HIV or HCV can spread rapidly within communities of PWID. For example, between 2011-16, HIV outbreaks ranging from <100 to >1000 newly reported cases occurred in communities in Canada, Greece, Ireland, Israel, Luxembourg, Romania, Scotland, and USA.<sup>19</sup>

The failure to scale-up effective harm reduction interventions has contributed to very high rates of HIV and viral hepatitis among people who inject drugs. Globally, an estimated 15% of PWID (2.3 million) are living with HIV. More than half (52% or 7.8 million) have had an HCV infection at some point in their lives, while one out of five (39% or 5.7 million) have a current HCV infection and one out of 12 (8% or 1.2 million) have a current hepatitis B (HBV) infection (see figure B).<sup>18</sup> HIV prevalence is especially high among women who inject drugs – median 15%, compared to 9% among men – due in part to gender norms and inequalities, increased vulnerability to sexual and other violence, and engagement in unsafe sex work.<sup>3</sup>

**FIGURE B**

### Global estimates of people who inject drugs who are living with blood-borne viruses

**8.4%**

currently have **hepatitis B**

1,239,000

**15.2%**

are living with **HIV**

2,253,500

**38.8%**

currently have **hepatitis C**

5,756,000

Data source: Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *Lancet Glob Health*. 2023.

HIV and viral hepatitis prevalence among PWID varies considerably and is concentrated by region. HIV and current HCV prevalence is highest in eastern Europe (34% and 48%, respectively) and Latin America (31% and 44%, respectively); HBV prevalence is highest (16%) in east and southeast Asia<sup>18</sup> (see figure D). In a 2019 systematic review, among all PWID who were living with HCV infection, half were from just four countries: Brazil, China, the Russian Federation, and the United States.<sup>20</sup>

In a recent modelling study, eliminating HCV transmission among PWID – despite their comprising only a very small percentage (<0.5%) of the population – would prevent 43% of all new HCV infections over 12 years.<sup>21</sup>

Despite the availability of effective treatments, people who inject drugs suffer much higher HIV- and viral hepatitis-related morbidity and mortality, compared to people who do not inject drugs. Globally, the number of deaths directly or indirectly attributed to drugs increased by 17% between 2010-2019. In 2019, of the 500,000 deaths related to drug use, 57% were due to HCV-related liver cancer and cirrhosis, a proportion that is increasing, while 15% were attributable to HIV, a proportion that has declined over the past decade<sup>17,22</sup> (see figure C). HIV remains the leading cause of death among PWID who are living with HIV, however, a rate that significantly exceeds that among people living with HIV who do not inject drugs.<sup>23</sup>

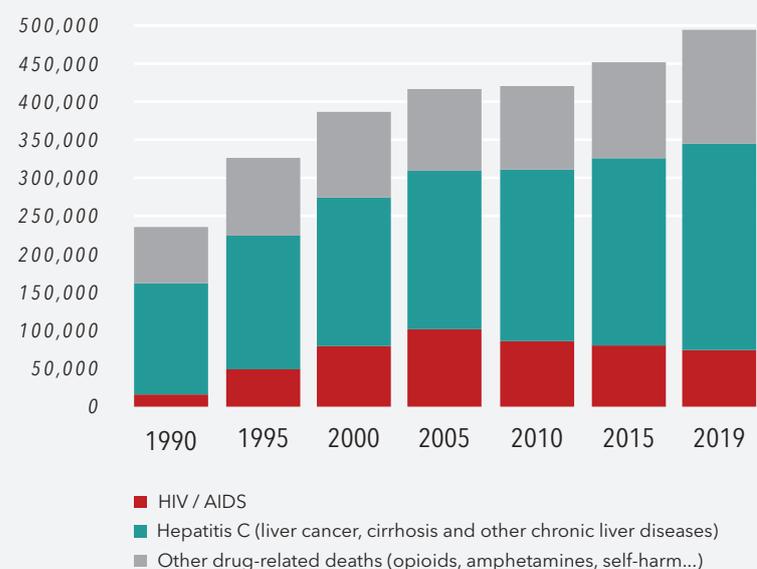
For people who inject drugs, the risks for HIV co-infections – i.e., HIV/HBV, HIV/HCV, or HIV/tuberculosis – are pronounced and represent an additional threat.

In 2015, **2 700 000** people were co-infected with HIV/HBV, while **2 300 000** people were co-infected with HIV/HCV

Because of similar transmission routes, the HIV and viral hepatitis epidemics overlap. Poor health outcomes and deaths are even higher among people coinfected with HIV and HCV or HBV – more than half of whom are PWID. Among people living with HIV, untreated hepatitis coinfection promotes more rapid progression of hepatitis-related liver disease,

**FIGURE C**

### Deaths attributed to drug use over 3 decades

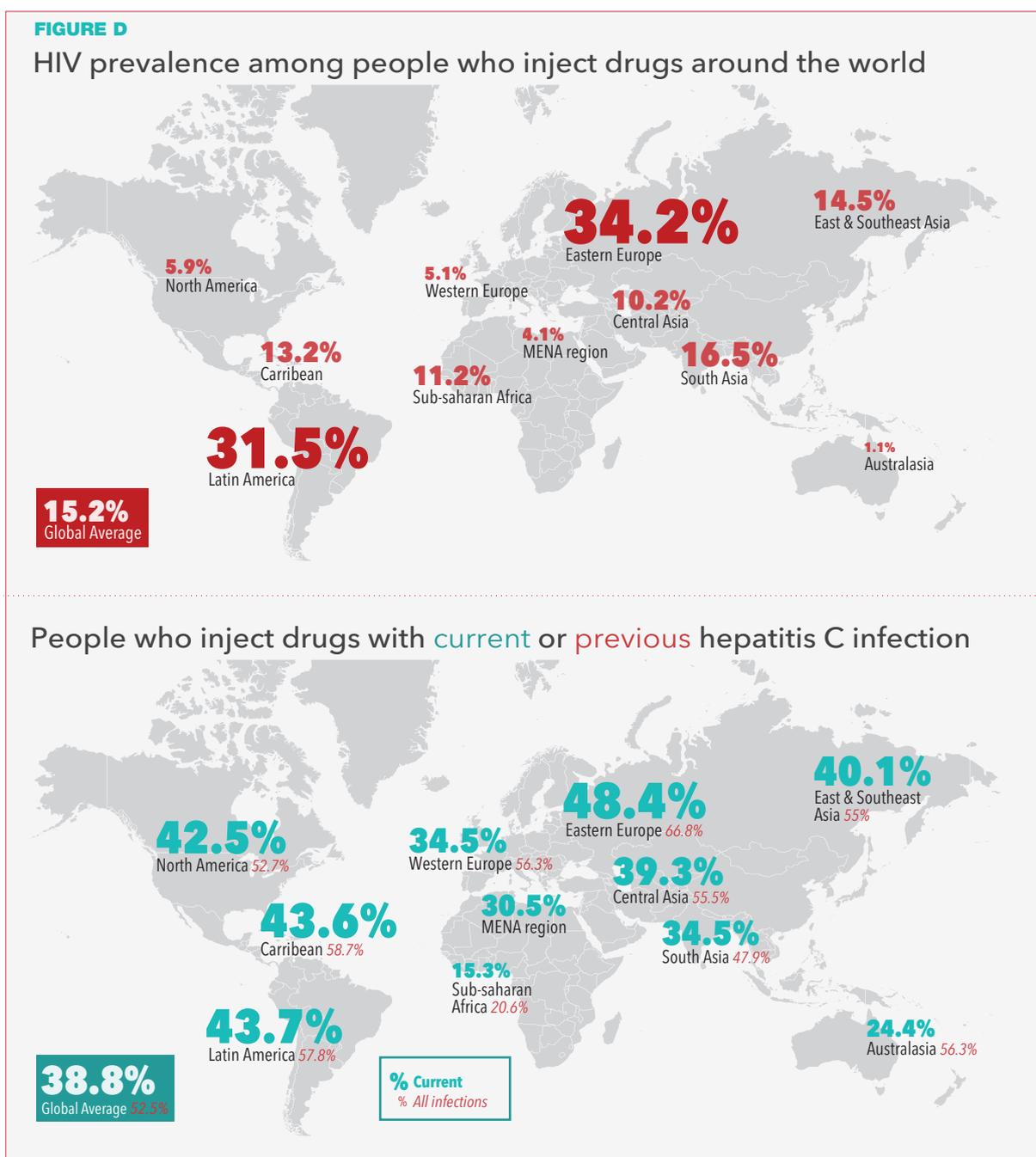


Data source: UNODC. World Drug Report 2023 (executive summary). Vienna; 2023.

cancer and untimely death, undermining the gains of effective HIV treatment.<sup>6</sup> PWID are also at increased risk of tuberculosis, irrespective of their HIV status, and tuberculosis is a leading cause of HIV-related mortality among PWID.<sup>24</sup>

Sexualized drug use (“chemsex”) may also increase risks for HIV and viral hepatitis. Chemsex – i.e., the use of substances, often stimulants (only sometimes

injected), to increase the occurrence of sexual activity or to enhance sexual experience – appears to be a relatively recent and growing phenomenon. It has been reported primarily among gay men and other men who have sex with men in North America, Europe, and increasingly, Asia.<sup>3</sup> Chemsex is associated with an increased risk for HIV and viral hepatitis infection, and for people living with HIV, may complicate the HIV care cascade.<sup>25</sup>



Data source: Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review. *Lancet Glob Health*. 2023

## HIV and viral hepatitis in prisons

The criminalization of drug use and possession has led to the mass incarceration of people who use drugs – sharply escalating their risks for HIV, HCV and other adverse health outcomes, both while imprisoned and after release.

Globally, an estimated 10.7 million people are held in penal institutions on any given day.<sup>26</sup> Due to the criminalization of drug use, people who use drugs are far more likely to encounter the criminal justice system – among PWID, 42% had been arrested, while 29% had been incarcerated in the previous 12 months.<sup>18</sup> As a result, particularly in regions with high prevalence of injecting drug use (such as Asia, eastern Europe and North America), people living with HIV and/or HCV are often concentrated in criminal justice settings.

For people living with or at risk for HIV or viral hepatitis, prisons represent a uniquely risky environment. Unsafe drug injection and unprotected sex (the occurrence of which are frequently denied by prison authorities), sexual violence and tattooing/piercing all facilitate transmission of HIV, HBV and HCV within prison and in the community upon release. For people who are incarcerated while receiving treatment for HIV, viral hepatitis or drug dependence, detention is often associated with treatment interruption. The availability of health-care in prisons is often subpar, particularly for HIV or viral hepatitis care. Discharge can be extraordinarily hazardous for people who resume opioid use after having ceased while incarcerated, who are three to eight times more likely to overdose due to decreased tolerance.<sup>27</sup> Increased risks persist after release – recent incarceration is associated with an 81% and 62% increased risk of HIV and HCV acquisition, respectively.<sup>9</sup>

Harm reduction coverage in prisons is effective – but rare. Among people in prison, OAT is effective in reducing unsafe injections and injection frequency.<sup>28</sup> OAT is also associated with a lower risk of mortality during incarceration, upon release, and after release.<sup>29</sup> And yet the availability of harm reduction interventions in prisons remains dire – only nine countries operate NSP in prisons: Armenia, Canada, Germany, Kyrgyz-

stan, Luxembourg, Moldova, Spain, Switzerland and Tajikistan. The number of countries providing OAT in prisons is unchanged since 2020 at 59.<sup>30</sup>

## Harm reduction: HIV and viral hepatitis prevention among people who use drugs

Harm reduction works. To reduce HIV and HCV infections and prevent overdose fatalities, WHO recommends a package of harm reduction interventions for PWID, including NSP, OAT for opioid dependence, as well as take-home naloxone for overdose management. Multiple international organizations (including WHO, UNAIDS, UNODC, the Global Fund and the Office of the High Commissioner on Human Rights) endorse a harm reduction strategy based upon health and human rights rationales.

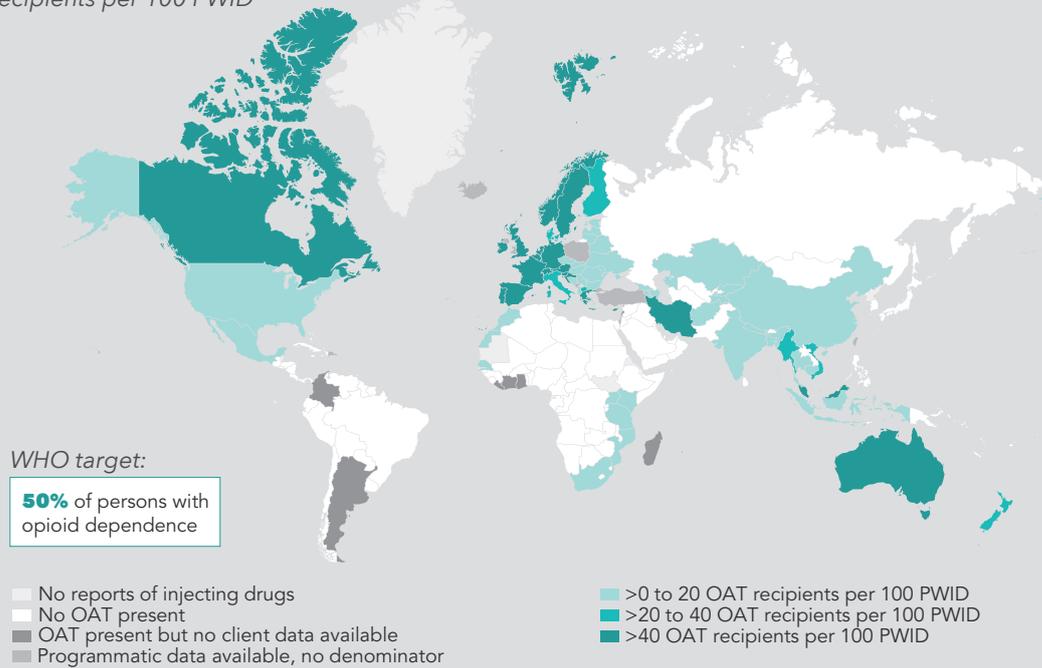
With severely inadequate funding, global coverage of harm reduction programs is far below what is needed. Funding for harm reduction is woefully inadequate and is heavily dependent on international donors – primarily PEPFAR (which prohibits the purchase of syringes) and the Global Fund. According to Harm Reduction International (HRI), current funding in low- and middle-income countries accounts for only 5% of the estimated US\$2.7 billion needed by 2025.<sup>31</sup> As a result, fewer than one percent (1%) of PWID live in countries with a full complement of harm reduction services, while many countries have no harm reduction services at all. Moreover, progress has stalled over the past seven years – then, as now, only five countries (all high income, accounting for 2% of PWID) provided high coverage of both OAT and NSP<sup>24,32,33</sup> (see figure E).

Needle-syringe programs remain the gold standard for reducing bloodborne infections among people who inject drugs. Nearly 30 years of research has shown that NSP are safe, effective and cost-saving, neither increase drug use nor crime, and with sufficient coverage, play a key role in reducing the incidence of HIV, HCV and other blood-borne infections.<sup>34-36</sup> And yet NSP coverage in most of the world remains low (in 48 countries that account for 73% of the global population of PWID) to moderate (in 15 countries that account for 5% of the global population of PWID).<sup>32</sup>

**FIGURE E**

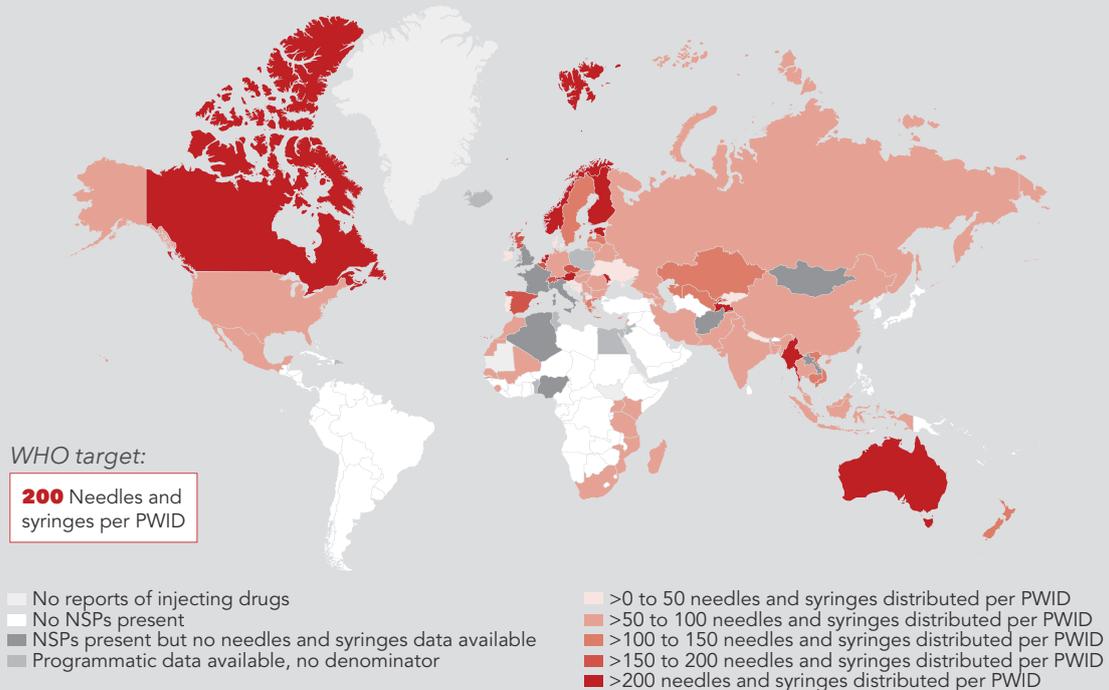
## Global coverage of opioid agonist treatment (OAT)

Recipients per 100 PWID



## Global coverage of needle-syringe programs (NSP)

Needle and syringe distribution per PWID per year



**Data source:** Colledge-Frisby S, Ottaviano S, Webb P, Grebely J, Wheeler A, Cunningham EB, et al. Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: a systematic review. *Lancet Glob Health*. May 2023.

## CASE STUDY

# The role of Georgia's national hepatitis C elimination program in strengthening harm reduction

Georgia, a small middle-income country in the South Caucasus with a population of 3.7 million, launched one of the world's first national HCV elimination programs, substantially changing the course of its epidemic.

In 2015, Georgia faced a significant challenge, with an estimated 5.4% of the adult population (150,000 adults) living with current HCV infection. Meanwhile, estimates suggest that Georgia was home to approximately 51,000 PWID – 1.4% of the general population, among the highest rates in the world – while a national serosurvey identified injecting drug use as one of the main HCV transmission risk factors. While HIV prevalence among PWID had remained relatively low, HCV prevalence was estimated to be 60-90%. Based on these data, Georgia decided to act boldly.

Thanks to strong political commitment and with the support from the US Centers for Disease Control and Prevention, WHO, and many private sector (including Gilead and others), national and international partners, Georgia's ground-breaking national HCV elimination program targeted a 90% reduction in HCV prevalence by 2020. Even though operating in the context of Georgia's strict drug policy laws, the program substantially improved the health and human rights of Georgian people who use drugs by:

- *Prioritizing PWID for HCV services, with decentralized, point-of-care testing and treatment integrated in harm reduction sites, HCV self-testing pilots, and peer-support interventions.*
- *Designating harm reduction as a national-level strategy to prevent HCV and improve access to HCV care, resulting in improved NSP and OAT coverage.*
- *Making communities equal partners in planning, implementing, and monitoring interventions to address the health of PWID, improving advocacy, awareness, education and partnerships.*

Since the program's launch, Georgia has made significant progress: almost 3 million people have been screened for HCV, while over 82,000 patients started treatment by mid-2023. A 2021 serosurvey showed that since 2015, current adult HCV prevalence decreased by two-thirds – from 5.4% to 1.8%.<sup>57</sup> The program also proved influential in advocating for increased funding for OAT programs, which fully transitioned to state funding in 2017 – helping to increase enrolment three-fold, from 4,800 in 2017 to 13,500 in 2021.<sup>58</sup>

### **Ketevan Stvilia**

National Center for Disease Control and Public Health, Georgia

### **Maka Gogia**

Georgian Harm Reduction Network, Georgia

### **Antons Mozalevskis**

World Health Organization, Switzerland

*Xenon harm reduction site in Zugdidi, Georgia, which offers point-of-care HCV diagnostics and decentralized, low-threshold HCV treatment. © Georgian Harm Reduction Network*



Treating drug dependence also reduces risks for HIV and viral hepatitis. Opioid agonist treatment (OAT), where participants receive a prescription medication as a substitute for an illicit opiate such as heroin, is the most effective treatment for opioid dependence and a key component of harm reduction programs, having also been shown to reduce blood-borne infections and overdose fatalities, and to improve a variety of other health outcomes.<sup>15</sup> While most OAT programs prescribe only a limited range of medications, usually methadone or buprenorphine (both classified by WHO as essential medicines), in some countries programs also employ other drugs, including hydromorphone or slow-release morphine (both prescription painkillers) or diacetylmorphine (pharmaceutical grade heroin). In an ideal setting, clinicians and program participants select the optimal medication from among a variety of options.

Even where available, however, OAT regimens are often needlessly restrictive and therefore limit uptake. Many programs offer only a single drug, and participants are rarely given input into the dose that might be most effective. Participants are often required to make daily visits to a clinic to secure a dose and are sometimes forced to demonstrate abstinence via drug testing. In some settings, OAT is restricted to PWID, creating a perverse incentive for some to transition to a more harmful mode of drug use to qualify for treatment.

Coverage for OAT programs remains far below targets, however, particularly in low- and middle-income countries. In Russia, where half of 1.3 million PWID are living with HIV, OAT is prohibited by law.<sup>3</sup> In a recent modelling study, scaling up to 40% OAT coverage would decrease deaths among people who use drugs by up to 25% over 20 years in three settings with diverse HIV- and drug-related mortality: Kentucky (USA), Kyiv (Ukraine), and Tehran (Iran).<sup>38</sup>

Providing both needle-syringe programs and opioid agonist treatment is particularly effective. In Switzerland, which in the 1980's implemented the then-innovative "four pillars" approach (prevention, treatment, harm reduction and law enforcement) in response to a pronounced HIV epidemic among PWID, new HIV infections were essentially eliminated – a 2018 modelling study showed that were it not for these measures, Swit-

zerland would have seen more than 15,000 additional HIV infections and 5000 additional AIDS deaths, reaching a peak HIV prevalence greater than 50%.<sup>39</sup>

Another recent modelling study suggests that even in such hard-hit settings such as Russia, these measures could reverse the epidemic. For example, scaling up ARV treatment in combination with NSP and OAT would avert over half of new infections and HIV-related deaths in settings with expanding epidemics like Omsk, and over a third of new infections, HIV and overdose deaths in settings with high prevalence, like Ekaterinburg.<sup>40</sup>

People likely to witness an opioid overdose (including in prisons) should have access to naloxone and be instructed in its use. Naloxone can immediately reverse an opioid overdose and has proved to be a critical intervention in the context of the opioid overdose epidemic. Because it cannot be self-administered, community-led programs are essential in ensuring that naloxone reaches PWID, their friends, family members, colleagues, and acquaintances.<sup>24</sup> Concerns that take-home naloxone would lead to increased substance use or overdose have not been substantiated.<sup>41</sup>

### **Innovative harm reduction strategies: preventing HIV and viral hepatitis, and promoting health**

The drug user movement created harm reduction, while the harm reduction sector continuously pioneers new approaches. Over decades, the harm reduction community has pioneered innovative programs, including community naloxone distribution, drug consumption rooms, and safe supply initiatives. And yet these interventions, which have been shown to mitigate structural risk factors and help people avoid practices that put their health at risk, are inaccessible to most people who use drugs.

More recent innovations, again spearheaded by the harm reduction community, include low dead space syringes to reduce blood residue and help prevent transmission of blood-borne viruses, along with interventions that provide alternatives to the frequent injection of stimulants, such as gel capsules and safer inhalation kits.<sup>42</sup>

Drug consumption rooms offer a safe, supervised space in which to use drugs, providing participants with security and stability, and enabling them to reduce their risks and access other services. Most drug consumption rooms offer sterile equipment, immediate overdose response, as well as other benefits including overdose trainings, take-home naloxone, NSP, psychosocial support and referrals to other health and social services. While most drug consumption room visitors inject opiates, some inject other drugs (primarily stimulants) or use drugs administered via other routes, such as smoked crack cocaine.

In the immediacy of the overdose crisis and recognizing the unlikely scale-up of drug consumption rooms to a level commensurate with the need, North American drug user groups recently pioneered pop-up “overdose prevention sites,” a low threshold alternative to a more clinical model, set up by volunteers and community-led organizations.

Drug consumption rooms are associated with decreases in overdose fatalities, public injecting and injection-related litter, and crime in surrounding communities. They have been shown to be effective in attracting and retaining people who use drugs, many of whom face structural vulnerabilities such as homelessness. Many drug consumption rooms provide linkages to HIV or viral hepatitis care, either onsite or via referral, including counseling, testing, and treatment initiation.<sup>43</sup> They also reduce non-sterile injections associated with HIV or HCV transmission and increase access to drug dependence treatments.<sup>44</sup>

As of mid-2022, there were drug consumption rooms operating in 17 countries in Australasia, eastern Europe, Latin America, North America, and western Europe.<sup>32</sup> To date, there are no drug consumption rooms in Asia, Africa, Eurasia or the Middle East.<sup>30</sup>

For decades, in addition to methadone- or buprenorphine-based OAT, some countries have offered additional medication options. Heroin-assisted treatment, for example, provides participants with pharmaceutical grade heroin (diacetylmorphine), and has been available for decades in Europe and Canada. While generally designed for those who have failed to benefit from methadone or buprenorphine and often offered in the context of a research trial, a limited number of countries now permit heroin-assisted treatment outside of a research setting

– for example, in Switzerland, physicians may prescribe a 6-day take-home supply of diacetylmorphine tablets or nasal nebulizer. A recent systematic review found that heroin-assisted treatment retained people in treatment and reduced consumption of illicit drugs more consistently than methadone-based treatment.<sup>45</sup> More recently, a small number of countries have approved additional opioid agonist medications. In Canada, for example, several provinces have approved the provision of injectable hydromorphone as a treatment for opioid dependence.<sup>46</sup>

In Switzerland, home to some of the most progressive drug policies in the world, clinicians and patients select among various drugs – with no regulatory distinction between office-based or institutional settings, take-home dosages or supervised intake, or among buprenorphine, methadone, and slow-release morphine.<sup>47</sup> In the best of all possible worlds, to maximize uptake and retention, all OAT programs would offer a variety of medications.

Recent initiatives offer a ‘safer supply’ of medical-grade drugs as an alternative to a toxic illicit drug supply. Structural factors associated with criminalization – i.e., violence, arrest, incarceration, a contaminated drug supply – sharply increase health and other risks for people who use drugs, particularly fatal overdose. Recently, the extensive contamination of the illicit drug supply with fentanyl in North America has led to the proliferation of drugs of unknown purity or potency, further increasing the risk. In response, there have been various initiatives to provide a “safe supply” of drugs, beyond the context of OAT.

While OAT programs aim to mitigate structural risks by substituting a licit drug for an illicit one (i.e., provide a “safe supply”) most are designed with the goal that clients stop taking drugs. Recently, some countries have explicitly initiated safe supply initiatives that do not focus on stopping drug use. For example, new regulations in Canada permit practitioners in a range of settings (medical clinics, supportive housing, community pharmacies, community health centers, and drug consumption rooms) to prescribe opioids, stimulants, and benzodiazepines.<sup>48,49</sup>

Among people who inject drugs, PrEP has potential, but evidence is limited. There has been little research to investigate the efficacy of PrEP to prevent parenteral transmission, and few initiatives to

expand PrEP for sexual transmission among PWID. Estimates suggest that PrEP is 74% effective in preventing HIV transmission among PWID, though more research is clearly needed.<sup>24,50</sup> It is also important to understand the acceptability of PrEP among PWID, and how best to maximize uptake and effective use. The drug user-led community has expressed concerns about the promotion of PrEP among people who use drugs in the context of insufficient access to NSP, which is known to be effective.<sup>51</sup> New, long-acting injectable ARV that require only infrequent administration were recently approved for PrEP in the USA and UK and show promise for use among PWID, as they may alleviate some access barriers.<sup>52</sup>

the risk for sexual HIV transmission to zero. Similarly, for people living with HCV, appropriate testing and diagnosis, followed by linkage to care and receipt of direct-acting antiviral treatment, is curative. A recent modelling study found that even a modest scale-up of HCV treatment and harm reduction among PWID could achieve global HCV elimination goals.<sup>53</sup>

HIV and viral hepatitis testing and treatment coverage among people who use drugs is poor. For people who use drugs, stigmatizing attitudes from health care workers, or discriminatory barriers to (or denial of) health care services, can negatively impact access to HIV and viral hepatitis testing, linkages to care, receipt of treatment – and ultimately, its success. For example, among people newly diagnosed with HIV, PWID are nearly twice as likely to experience a delay in linkage to care. HBV or HCV infection are also associated with delays.<sup>23</sup> In a recent systematic review, global HIV and HCV testing and treatment uptake among PWID were far below targets and varied substantially by country – an estimated 49% (ranging from 1–86%) had been tested for HIV, while 47% (ranging from 0–93%) had ever been tested for HCV antibodies. While data are insufficient to estimate global HIV or HCV treatment uptake, among countries with available data, estimated current HIV treatment ranged from 3–82%, while estimated ever having had HCV treatment ranged from 2–89%.<sup>54,55</sup>

In a clear violation of international human rights laws and despite robust evidence that HIV and HCV treatments are as effective among people who use drugs as they are among people who do not, many countries condition the receipt of ARV or direct-acting antiviral treatments on sobriety.

Beyond official proscription, physicians sometimes withhold treatment from people who use drugs because of fears they will not adhere to treatment regimens and develop drug resistance, even though research has consistently demonstrated that among people who use drugs, medication adherence, rates of viral suppression, and loss to follow-up is similar, or sometimes better than that in other subpopulations.<sup>23</sup> In an HCV treatment study among PWID in seven countries, successful treatment rates were 94% (similar to those seen in studies among people who do not inject drugs), irrespective of drug use before or during HCV treatment.<sup>56</sup>



First Syringe dispensing and exchange machine in Paris on December 1<sup>st</sup>, 1994, France. © Nicolas Le Corre / Gamma-Rapho

## HIV and viral hepatitis testing and treatment among people who use drugs

Available treatments for HIV and HCV are effective. For people living with HIV, testing, linkage to care, followed by receipt of and adherence to ARV treatment, are key predictors of survival. Additionally, when ARV treatment is taken regularly and consistently, it results in viral suppression, which has been shown to reduce



# DRUG POLICY REFORM AS A PATH TO END HIV AND VIRAL HEPATITIS

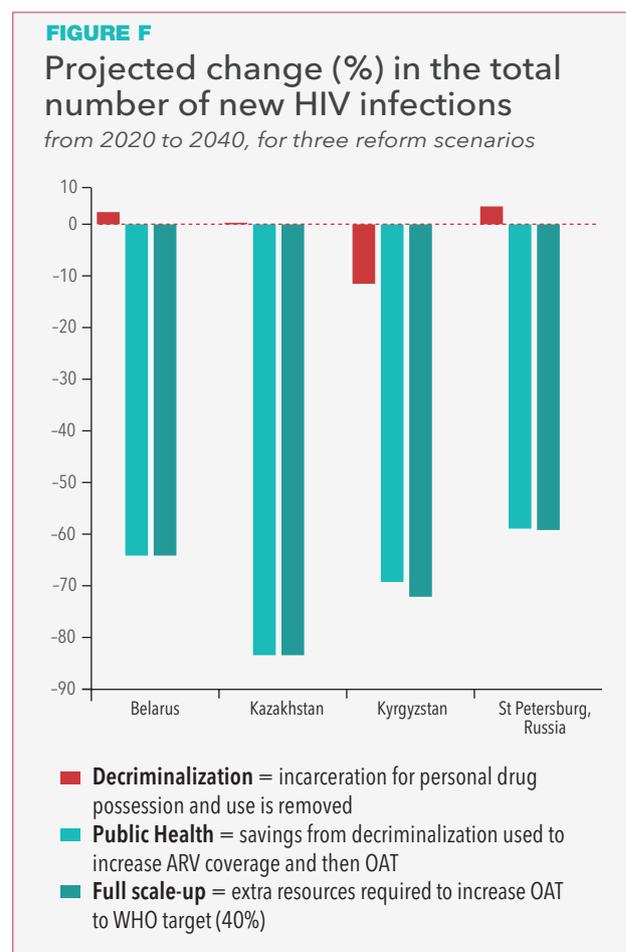
Ending HIV and eliminating viral hepatitis among people who use drugs will require broad drug policy reform: decriminalizing drug use and possession, reducing barriers created by the criminalization of drugs, and scaling up health services designed to meet their needs. The Global Commission on Drug Policy has long recommended such a path to effectively respond to HIV and viral hepatitis.<sup>71-73</sup> This approach has also been endorsed by a range of international human rights bodies and has subsequently been adopted across the entire UN system through a common position on drug policy.<sup>24,74-77</sup> Along with legal reforms, a comprehensive package of health interventions – harm reduction, PrEP for HIV, HBV vaccination, HIV and viral hepatitis testing and treatment, as well as screening, diagnosis and prevention of HIV-related tuberculosis – should be complemented with interventions to reduce structural barriers, stigma and discrimination, and to empower communities.

## Decriminalizing drug use, drug possession, possession of drug paraphernalia... and people who use drugs.

Decriminalization is an essential precursor to ending HIV and eliminating viral hepatitis as a public health threat. The vast majority of countries continue to criminalize the use or possession of drugs, which will thwart global efforts to end HIV and eliminate viral hepatitis by 2030. Moreover, this failed approach comes at enormous cost. In a recent modelling study in two high-HIV prevalence areas (eastern Europe and central Asia), the cost savings from decriminalization would be sufficient to scale-up ARV treatment and OAT to meet UN targets with little or no additional investments, could reduce HIV incidence by three-quarters among PWID, and would ultimately be cost-saving (see figure F).<sup>78</sup>

Beyond doing away with criminal penalties, decriminalization requires the elimination of all sanctions for drug use or possession. While decriminalization entails eliminating criminal sanctions, they are sometimes replaced with fines or other administrative penalties. Such civil sanctions can have the perverse effect of increasing interactions between people who use

drugs and the authorities, and fall short of full decriminalization, which according to the International Network of People who use Drugs (INPUD), “requires a meticulous dismantling of the structures, policies, and practices of prohibition and its associated harms...”<sup>79</sup>



*Data source:* Ward Z, Stone J, Vickerman P, Heimer R, El-Bassel N, Ward Z, et al. Costs and impact on HIV transmission of a switch from a criminalisation to a public health approach to injecting drug use in eastern Europe and central Asia: a modelling analysis. 2022.

In the process of decriminalization, the alternatives to incarceration must be appropriate, proportionate, and voluntary. In instances where drug use and/or possession are partially decriminalized but civil fines or administrative penalties are retained or imposed, it is important that such alternative measures be proportional – that their severity reflects the relatively minor (i.e., decriminalized) offense. High fines, which place a financial burden on people who use drugs and their families and can result in imprisonment, are also unreasonable.

## CASE STUDY

# Accelerating progress towards hepatitis C elimination among people who inject drugs: Lessons from Australia

 As one of 11 countries “on-track” to achieve 2030 HCV elimination targets, Australia offers lessons for the world, particularly with respect to its approach to people who use drugs. In Australia, 81,300 people are living with current HCV infection,<sup>59</sup> and most new (90%) HCV cases occur among PWID. It is estimated that 75,000 people regularly inject drugs in Australia,<sup>60</sup> with 12% having current HCV infection.<sup>61</sup>

Key features of the successful Australian HCV response include a history of national strategies (the first in 2000, with the sixth [2024-2030] underway), strong stakeholder partnerships, bipartisan government support and leadership, and government funding for community-based organizations.<sup>62</sup> Education and training for primary care and drug treatment providers has also been critical.<sup>62</sup> The broad implementation of NSP and OAT from the early 1990s has maintained a low HIV prevalence among PWID (~1%), prevented many HCV infections,<sup>63</sup> and is cost-saving.<sup>63</sup> The lack of NSP and low OAT coverage in prisons has been suboptimal (although OAT access has improved with the availability of long-acting buprenorphine).

Australia was among the first countries in the world to provide broad access to direct-acting antiviral HCV therapies, with no restrictions based on disease stage, drug/alcohol use, or prescriber type – as of 2022, 105,024 people had been treated.<sup>64</sup> Uptake has been higher among PWID and people who are drug dependent compared to low-risk populations, and HCV treatment uptake among PWID<sup>61,65</sup> increased from 11% in 2015 to 68% in 2022.<sup>61</sup> Prisons account for 41% of all people treated in 2021.<sup>66</sup>

Increased HCV testing and treatment have been associated with a decline in current HCV prevalence from 51% in 2015 to 12% in 2022.<sup>61</sup> HCV incidence has more than halved from 2010-15 to 2016-21.<sup>67</sup>

HCV care is integrated in drug treatment clinics, NSP, mobile outreach services, and prisons. In 2022, 52% of HCV treatment prescriptions were written by non-specialists (e.g. general practitioners and nurse practitioners).<sup>64</sup> A National HCV Point-of-Care Testing Program has been critical to decentralize testing and treatment.<sup>68</sup> Interventions such as dried blood spot testing<sup>69</sup> and point-of-care testing<sup>69</sup> have improved testing rates, particularly among PWID.<sup>68</sup>

Community-based organizations have played a critical role in the development, implementation, and monitoring of new programs to enhance testing and treatment access (including peer-based support and community-led models of care).<sup>70</sup>

Moving forward, considerable work is needed to address stigma and discrimination among PWID accessing healthcare services. While the Australian Capital Territory has decriminalized the possession of small amounts of drugs, further work is needed for a national response. Dedicated funding to support the upcoming 6th National HCV strategy (2024-30), particularly focusing on issues of equity, will be critical.



**Jason Grebely & Gregory J Dore**

The Kirby Institute, UNSW, Sydney, Australia

## CASE STUDY

# International Network of People who Use Drugs (INPUD) case study: Peers on Wheels (POW) Project

**//** In New South Wales, Australia, the innovative POW (Peers on Wheels) Project recently demonstrated the potential for peer experts to contribute to national HCV elimination efforts. In a one-year trial, the initiative provided low barrier, same day HCV testing with linkages to liver assessment and treatment, including HIV and HBV testing and harm reduction (i.e., NSP and naloxone) services, improving access among marginalized people. Peer-led, POW was a partnership among NUAA (New South Wales Users and AIDS Association), the New South Wales Ministry of Health, and The Kirby Institute UNSW.

The POW Project conducted 12 weekly fieldwork events in a range of settings across New South Wales, including metropolitan locales, large satellite towns, regional towns, and small rural townships. POW utilized a mobile van to establish services in community settings, covering more than 10,000 kilometers in under 12 months. In partnership with clinical and specialist health services, the van visited alcohol/drug treatment parking lots, municipal parks, community centers, homeless centers, pharmacies and allied services.

Critically, POW was peer-led, and lived/living experience peers were central to the project's operations, coordinating stakeholder partnerships and leading service provision and oversight. Local peers assisted with promotional efforts, connecting individuals in local user networks to the Project. Peers were trained to operate point-of-care equipment, conducting RNA and antibody testing with same day results. Peers also led research components of the Project, from participant engagement to obtaining informed consent, self-report questionnaires, and finger-prick blood samples. Finally, peers led all data entry and project reporting.

More than 600 individuals participated in the Project. Of those testing positive for current HCV infection, more than a third were connected with local health services, many of whom successfully completed direct-acting antiviral HCV treatment.

**Charles Henderson**  
Sydney, Australia



Compulsory treatment, with or without detention, is never acceptable. Compulsory drug “treatment” programs (often abstinence-based) exist in a variety of settings, from “civil commitment for substance abuse” statutes in the USA, to compulsory drug treatment in Sweden, to detention facilities for people who are perceived or known to be using drugs across southeast Asia (Cambodia, China, Lao PDR, Malaysia, Philippines, Thailand and Viet Nam). In addition to significant human rights concerns, coerced abstinence may pose significant, even fatal health risks, similar to well-documented elevated risks for overdose, HIV and HCV faced by people who use drugs who are released from prison.<sup>80</sup>

Laws prohibiting “incitement” or “encouragement” of drug use should not be used to restrict the possession or distribution of harm reduction equipment, goods or information. In many jurisdictions around the world, harm reduction programs (e.g. OAT, sterile injection equipment) are hampered by criminal or other prohibitions on the delivery of services needed by people who use drugs, including in prisons and other closed settings.

Anti-discrimination laws and policies are needed to protect people who use drugs. Criminalization is state-sanctioned stigmatization of, and discrimination against, people who use drugs. It also serves as an excuse for the stigmatization and social control of people who use drugs by law enforcement and others and has been used to justify punitive measures and practices that target, harass, extort and otherwise abuse people who use drugs, which can in turn impede harm reduction efforts. To address this insidious impact, it is essential to implement and enforce antidiscrimination and protective laws, based upon human rights standards, to mitigate stigma, discrimination and violence against people who use drugs.

### **A health- and human rights-centered approach to drug policy**

**“The ‘war on drugs’ may be understood to a significant extent as a war on people.”**

— UN independent experts and special rapporteurs, International Day Against Drug Abuse and Illicit Trafficking, 2023 <sup>81</sup>

Laws, regulations, policies and practices that criminalize and otherwise punish people because of their real or perceived drug use or possession are incompatible with the human right to the highest attainable standard of physical and mental health. They also violate an array of other human rights, including non-discrimination, privacy, autonomy, dignity, freedom of expression, freedom from arbitrary detention, and ultimately the right to life.

Widespread human rights violations or abuses associated with drug control policies – discrimination, extrajudicial executions, torture, arbitrary detention, police abuses, and the continued use of the death penalty for drug-related offenses – constitute violations of economic, social, and cultural rights, including the right to health, and have been well documented.<sup>82</sup>

Drug control efforts must be centered on human rights, including the fundamental right to health. This means that governments have an affirmative obligation to ensure that people who use drugs have safe, effective access to prevention, testing and treatment services, including harm reduction services, which should be adequately funded, appropriate for their needs and circumstances, and respectful of human dignity.

Recently, the UN Office of the High Commissioner for Human Rights released a landmark report calling for transformative change, noting the far reaching and severe human rights violations resulting from punitive global drug control policies. The report affirms that harm reduction is a central element to the right to health, highly recommends the decriminalization of drug use and possession for personal use, and – for the first time by a UN body – calls upon member states to consider the legal regulation of drugs as a way to combat illicit drug markets.<sup>83</sup>

### **Health care that meets the needs of people who use drugs**

HIV and viral hepatitis services should be integrated within programs that address the range of structural determinants of health that impact people who use drugs. People who use drugs experience a syndemic – a constellation of factors that amplify their risks for

HIV and viral hepatitis. Many of these intersections between HIV, viral hepatitis, and gender, disability, education, race, religion, socioeconomic status, or other factors are mediated by the criminalization of drugs. An optimal approach will integrate HIV and viral hepatitis testing and treatment services with other services at the same sites – including harm reduction sites, pharmacies, and prisons – and offer linkages to primary care.

New testing technologies may alleviate under-diagnosis, which remains a critical barrier to addressing viral hepatitis. More than 80% of people living with chronic HBV infection and 90% of people living with HCV infection remain undiagnosed. Rapid point-of-care tests for HIV, HBV and HCV make it possible to provide community-based or self-administered testing that can facilitate immediate treatment initiation, ideally on the same day. PWID should be prioritized for HCV testing and efforts should be made to identify reinfection among people with ongoing risks.

Task-shifting can alleviate HCV treatment bottlenecks faced by people who use drugs. Viral hepatitis interventions have traditionally been delivered through hospitals and by specialists, which can present barriers to people who use drugs. When appropriate, these services can be delivered by non-specialists (i.e., task-shifting), including primary care physicians and nurses with support from peer workers and patient navigators. While this approach has been successfully adopted to deliver HIV services among many populations, people who use drugs are often left behind.

HIV and viral hepatitis services must also be accessible for people who use substances other than opioids, or through routes of administration other than injecting, such as snorting, smoking or ingestion. HIV and viral hepatitis prevention and treatment services should be tailored and accessible not only to people who inject opioids, but also to people who use stimulants or other (injection and non-injection) drugs, and to address emerging forms of sexualized drug use (e.g., chemsex among gay men).

Tuberculosis is the leading cause of death among people living with HIV. People who use drugs are at elevated risk for tuberculosis. As such, timely di-

agnosis and treatment of tuberculosis is essential – including screening for symptoms, preventive treatment, HIV testing for all people with diagnosed or presumed tuberculosis, timely initiation of ARV treatment for people with tuberculosis, chemoprophylaxis and the treatment of drug-susceptible and drug-resistant tuberculosis.

### **The central role of people who use drugs in ending HIV and viral hepatitis**

People who use drugs make pivotal contributions to advocacy, service delivery, policymaking, monitoring and evaluation, as well as initiatives to address social and structural barriers. The involvement of people who use drugs can strengthen program development, design and delivery and promote accountability, including through community-led monitoring. Expanding the capacity of people who use drugs to provide services and commodities can also reach individuals missed through traditional clinic-based approaches, ultimately addressing major gaps in the HIV and viral hepatitis responses. Meaningful participation and leadership by and for people who use drugs ensures their specific needs are met in ways that are both beneficial and acceptable to them.

People who use drugs should be empowered and given the opportunity to participate in every aspect of policy and programmatic development, design, implementation, monitoring and evaluation. Empowerment can take many forms, such as support for community-led programs and service delivery, participation in designing and operating services, peer education or navigation, or task shifting to peers. With such support, people who use drugs can improve acceptability and uptake of programs, while in the process increasing control over their health and the health of their communities.<sup>76</sup> While difficult to measure, among key populations that include people who use drugs, community empowerment has been shown to have a measurable impact on health, including reductions in HIV incidence and unsafe sex.<sup>84</sup>

# RECOMMENDATIONS

## The Global Commission on Drug Policy calls on the United Nations to:

**Fully and effectively implement the UN Common Position on Drugs (2018), which calls for changes in laws, policies and practices that threaten the health and human rights of people.**

UN agencies should implement the *United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration*<sup>77</sup> through joint actions at regional and country levels to support decriminalization of drug possession for personal use and measures to reduce stigma and eliminate discrimination faced by people who use drugs.

## The Global Commission on Drug Policy calls on Member States to:

**Decriminalize drug use, drug possession for personal use, and the possession of drug paraphernalia.**

Decriminalization entails eliminating all punitive measures associated with drug use or possession. It is also critical to address police harassment, coercion, extortion and violence against people who use drugs.

Where drug use or possession remains illegal, people who use drugs must be guaranteed due process and judicial responses must be proportional. Legal impediments to opioid agonist treatment, or to the availability of harm reduction programs, such as drug paraphernalia laws, should be eliminated. The death penalty for drug-related offenses is a never justifiable violation of human rights that must be abolished.

**Implement antidiscrimination measures to protect people who use drugs from discrimination in accessing benefits or services, including healthcare, education, housing, social benefits, and employment.**

**Ensure the availability of drug dependence treatment.**

Opioid agonist treatment should be a basic and essential service standard for the treatment of opioid dependence.

Rigid requirements for daily clinic visits and observed dosing are demeaning and counter-productive, as they may limit retention and impede employment. Abstinence requirements or other conditions, such as compulsory psychosocial care or requirements for negative urine tests, constitute an unjustifiable barrier and should be eliminated.

Compulsory drug dependence treatment should be discontinued. Compulsory drug treatment detention centers must be closed.

**Fully resource and scale-up HIV and viral hepatitis prevention (harm reduction), diagnosis and treatment programs, including in prisons and other closed settings.**

Resources should be reallocated from prohibition-driven law enforcement to health programs, including HIV and viral hepatitis prevention and treatment.

HIV and viral hepatitis services should be integrated with programs to address overall health needs, including drug dependence treatment, mental health, and sexual and reproductive health services, and should be accessible and acceptable to people who use drugs.

At minimum, prevention programs should provide sufficient coverage of needle-syringe programs, opioid agonist treatment for opioid dependence, and take-home naloxone for overdose management.

Individuals who test positive for HIV or viral hepatitis should be offered treatment immediately and without conditions, preferably on the same day and at the same site. Ideally, rapid point-of-care diagnostic testing (for multiple pathogens) should be offered in settings that facilitate access, including primary care, harm reduction sites and prisons. Self-testing and community-led testing initiatives should be expanded.

HIV and viral hepatitis prevention and treatment services must be available in prisons and other closed settings, both when people are incarcerated and via linkages upon release.

**Support the exploration, development and evaluation of innovative harm reduction strategies – including drug consumption rooms, drug checking, heroin-assisted treatment and safe supply initiatives.**

Harm reduction strategies have the potential to mitigate the multiplicity of risks faced by people who use drugs and connect them with HIV, viral hepatitis and drug dependence treatment services. While many programs target people who inject opioids, some newer initiatives help people who inject non-opioid drugs such as stimulants, use non-injection drugs such as smoked crack cocaine, or use novel psychoactive substances.

**Involve people who use drugs in the design, implementation, monitoring and evaluation of all HIV and viral hepatitis programs.**

Many people who use drugs experience directly the harms caused by prohibition, including discrimination, incarceration, police violence and overdose, and are well positioned to understand and mitigate service barriers, contribute to program design, monitor the extent to which programs meet targets, and in many instances, deliver services, enhancing their effectiveness.

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- Drug Policy and Deprivation of Liberty (May 2019)
- Drug Policy and City Government (June 2021)
- Drug Policy in Colombia: the road to a just regulation (November 2022)

## **ADDITIONAL RESOURCES**

- [www.drugpolicy.org](http://www.drugpolicy.org)
- [www.eltonjohnaidsfoundation.org](http://www.eltonjohnaidsfoundation.org)
- [www.hri.global](http://www.hri.global)
- [www.hrw.org](http://www.hrw.org)
- [www.idpc.net](http://www.idpc.net)
- [www.inpud.net](http://www.inpud.net)
- [www.ohchr.org](http://www.ohchr.org)
- [www.tdpf.org.uk](http://www.tdpf.org.uk)
- [www.unaids.org](http://www.unaids.org)
- [www.unodc.org](http://www.unodc.org)
- [www.unhabitat.org](http://www.unhabitat.org)
- [www.unwomen.org](http://www.unwomen.org)
- [www.wola.org](http://www.wola.org)
- [www.who.int](http://www.who.int)

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## SECRETARIAT

Anna Tomasi  
Marilena Genco  
Jennifer Hasselgård-Rowe

## CONTACT

[secretariat@globalcommissionondrugs.org](mailto:secretariat@globalcommissionondrugs.org)  
[www.globalcommissionondrugs.org](http://www.globalcommissionondrugs.org)

 [GlobalCommissiononDrugs](#)  
 [GlobalCDP](#)  
 [Global Commission on Drug Policy](#)



## GLOBAL COMMISSION ON DRUG POLICY

The purpose of the Global Commission on Drug Policy is to bring to the international level an informed, science-based discussion about humane and effective ways to reduce the harms caused by drugs and drug control policies to people and societies.

### GOALS

- Review the base assumptions, effectiveness and consequences of the “war on drug” approach
- Evaluate the risks and benefits of different national responses to the drug problem
- Develop actionable, evidence-based recommendations for constructive legal and policy reform