Agenda item 3

UNAIDS/PCB (59)/26.24

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 58TH PCB MEETING

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

UNAIDS

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Additional documents for this item: N/A

Action required at this meeting—the Programme Coordinating Board is invited to:

- *Take note* of the background note (UNAIDS/PCB (58)/26.19) and the summary report (UNAIDS/PCB (59)/26.24) of the Programme Coordinating Board thematic segment on “Beyond 2025: countering health inequities through sustaining the HIV response, human rights and harm reduction for people who use drugs”;
- Recognize the need to strengthen action to address the lack of significant progress in expanding harm reduction programmes that respect the dignity and rights of all persons, including people living with, at risk of or affected by HIV, and that are informed by comprehensive harm reduction interventions in line with national contexts;
- *Recalling* decision point 5.2 of the 53rd meeting of the Programme Coordinating Board, r*equest* Member States, in collaboration with community-led HIV organizations and other relevant HIV-related organizations, with the support of the Joint Programme, to:
    a. Collect and use disaggregated data, including community-generated data, to understand gaps in services and support decision-making on planning of HIV services for people who use drugs and targeted investment in harm reduction;
    b. Integrate harm reduction into national health systems and budgets, in ways that strengthen and sustain community leadership, including through social contracting;
    c. Create enabling legal and policy environments for effective HIV responses among people who use drugs and to reduce stigma and discrimination, including by revising national laws and policies in line with international human rights law;
    d. Advance and support legal and policy reforms that enable community-led organizations, including by people who use drugs, to register, operate and receive domestic and international funding for advocacy, service delivery and accountability, as essential steps towards sustainability in the HIV response.

Cost implications for the implementation of the decisions: none

Opening dialogue and keynote addresses

1. Daria Ocheret, Adviser, Community led Responses, UNAIDS, introduced the segment by calling for a minute of silence honouring the people who have lost their lives to the AIDS epidemic. She told the meeting that new HIV infections were increasing in many places among people who inject drugs, a trend driven by stigma and discrimination, inequalities and limited access to harm reduction services. Funding constraints and fragile service delivery systems were putting these populations at even greater risk. Ms Ocheret then outlined the agenda and the objectives of the segment.

2. Winnie Byanyima, Executive Director, UNAIDS, presented the opening remarks. She said fewer people were acquiring HIV and dying of AIDS-related causes, but the progress was not spread equally. People who inject drugs had a 34 times higher risk of acquiring HIV than the general adult population; in 2025, about 85 000 of them had acquired HIV. Highly effective preventive measures existed, she said, and 112 countries made explicit reference to harm reduction in national policy documents. Yet less than half of the people who inject drugs reported having access to HIV prevention services.

3. Ms Byanyima reminded the meeting that the Political Declaration on HIV/AIDS called for 90% of people in need having access to and using effective prevention options, including pre-exposure prophylaxis (PrEP), condoms and harm reduction services. However, in 2025 only Malaysia and Seychelles reported reaching the targets for opioid agonist maintenance therapy and only Bangladesh and Myanmar reported distributing the requisite numbers of clean syringes. People who needed HIV services the most were still being failed, she said, and were being pushed to the margins by stigma and discrimination, criminalization and neglect.

4. Yet there were also exciting examples of countries and communities acting to fill the gaps, said Ms Byanyima. Countries were seeking to understand and address the inequalities and structural barriers driving risk; advancing human rights; working with affected communities; and moving towards sustainable domestic funding for harm reduction. The thematic segment, she said, would provide examples of people's lived experiences and of interventions and changes that were working. She cited examples of progress in Kenya, Nigeria, Cambodia and cities in Poland, and elsewhere, which showed how countries can shift from punishment to uphold people's rights, health and well-being. UNAIDS was ready to work with partners and communities to turn the commitments in the Political Declaration into reality, she told the meeting.

5. Mathume Joseph Phaahla, Deputy Minister of Health, South Africa, thanked UNAIDS for its leadership in advancing a global HIV response that is guided by equity, human rights and sustainable development. He said inequalities continued to undermine collective progress, especially for key populations, with stigma and discrimination still presenting major barriers. He said there were indications of very high incidence among people who inject drugs, and that HIV treatment interruption was a major issue, due to migration, forced relocation by police, imprisonment, and other factors.

6. After noting that harm reduction was an evidence-informed public health approach, he said South Africa did not yet have a focused national harm reduction strategy. However, targeted interventions were carried out with civil society, with linkages to primary healthcare. Achievements included having two thirds of people living with HIV who inject drugs knowing their HIV status, 80% of whom were on treatment, with 46% of those on treatment having viral suppression. An opioid agonist therapy pilot project

was operating in two provinces, methadone had been included in the National Essential Medicines List, and some cities were providing harm reduction services, he told the meeting. Expanding such projects was challenging, however. Surveillance data for people who inject drugs were limited, making planning and tracking difficult. Mr Phaahla noted the important roles of communities in designing and implementing the necessary interventions and he underscored the role of primary healthcare as a basis for needed services.

7. Monica Juma, Executive Director of the United Nations Office on Drugs and Crime (UNODC), addressed the meeting via video. She reminded participants that people who use drugs were heavily affected by the AIDS epidemic. About 14 million people injected drugs globally, and an estimated 1.7 million of them were living with HIV and almost 7 million were living with hepatitis C. This showed that were many gaps in bringing HIV services to this population, she said. Yet the evidence showed clearly that when health services are accessible and respond to people's needs, infections decline and health outcomes improve. It was vital to remove barriers, including criminalization, and to support harm reduction, prevention and treatment as a continuum of care. It was also necessary to expand partnerships across sectors, establish meaningful engagements with communities, and invest in evidence-based approaches. She said UNODC would work with Member States and partners to expand HIV treatment for people who use drugs and to introduce prevention and other harm reduction services in prisons and other closed settings.

8. Anton Basenko, Executive Director, International Network of People Who Use Drugs (INPUD), shared some of his own experiences as a person with lived experience of injecting drugs and told the meeting that harm reduction services had saved his life, thanks to a community-led project which had treated him with dignity instead of judgement. Needle and syringe projects were often the first contact with healthcare for people who inject drugs, he said. Recalling his experiences trying to access opioid agonist maintenance therapy (OAMT), he said that the appropriate policies and services were never guaranteed: they had to be defended constantly. He also reminded the meeting that many of the same recommendations made at the current meeting had been made ten years earlier at the PCB. He said he hoped the same conversations would not be repeated in a decade’s time.

9. In the previous year, said Mr Basenko, an INPUD survey had shown that people who use drugs were facing an emergency that threatened their health, rights and dignity. In the context of recent policy and funding shifts, projects were being closed, outreach services were ending, and community organizations and networks were in crisis. Funding cuts were occurring alongside an increase in the use of punitive policies, all of which were pushing people who use drugs further underground. Yet the evidence showed that needle and syringe programmes connect people to healthcare services and reduce HIV transmission by around 50% and hepatitis C transmission by more than 70%. When these services disappear, Mr Basenko said, people do not stop using drugs; instead, their health is undermined.

10. Community-led projects build trust, increase uptake of HIV prevention, treatment and care, improve health outcomes and save lives, he said, and they there were facing an existential crisis due to funding cuts and legal restrictions. They urgently need flexible and predictable financing, he stressed. The interventions that had saved his life were not miracles, he said, but due to evidence-based actions that were made possible by brave political decisions. He appealed to Member States to realize their HIV commitments by funding harm reduction and by supporting community-led organizations. History would judge the world not on its declarations, but on whether it acted to save lives. Every person who uses drugs should have the same chance he

had been given—not by luck, but by design.

Setting the scene: presentation of background paper highlights (data)

11. Mary Mahy, Director, Data and Evidence at UNAIDS, presented an update on the epidemiology of HIV. She began by reminding the meeting that, behind the data she was discussing, were human faces. She said new HIV infections outside sub-Saharan Africa had stayed almost unchanged for the past 15 years and new infections were increasing in some regions. Those failures were due to a lack of evidence-driven HIV prevention interventions. She told the PCB that about 13% new infections outside sub-Saharan Africa were among people who inject drugs, 31% among gay men and other men who have sex with men, 6% among sex workers, 5% among clients of sex workers, and 5% among transgender women.

12. Those trends could be changed if people's human rights are upheld and the inequalities that shape their lives are reduced, Ms Mahy said. The HIV epidemic was having a disproportionate impact on people who inject drugs, but less than 1% of total HIV spending went to programmes for people who use drugs.

13. Young people (aged 15–24 years) who inject drugs were 50% more likely to acquire HIV and hepatitis C than adults. HIV prevalence was also higher among women who inject drugs than among their male peers (15% vs 9%). Geographically, HIV prevalence among people who inject drugs was higher in eastern Europe and central Asia (11%) and in Asia-Pacific (8%), making it important to focus on those regions. At the same time, though, there was a lack of reliable population size estimates and other relevant data on these communities, Ms Mahy said.

14. She told the Board that the evidence on harm reduction showed that access to needle and syringe and OAMT programmes did not increase drug use but did reduce HIV transmission and improved antiretroviral (ARV) treatment adherence among people who inject drugs. As an example, she cited Portugal's decision in the early 2000s to decriminalize drug possession for personal use and provide harm reduction services to people who use drugs. The number of people using heroin fell from 100 000 to 25 000 by 2017 and HIV transmission among people who use drugs declined sharply. In Fiji, by contrast, a major HIV outbreak occurred in 2024, with a substantial proportion of newly diagnosed people reporting injecting drug use as a primary risk. This occurred in a context of widespread stigma and discrimination, high-risk injecting practices, and limited availability of harm reduction service. Fiji was now considering introducing some harm reduction services, she said.

15. She reminded the meeting that the Political Declaration on HIV/AIDS calls for 90% of people who need HIV prevention accessing and using prevention services. In 2024, only about 39% of people who inject drugs had such access. Treatment coverage was higher but still far from the levels needed. Only five countries were meeting the global needle and syringe programme and OAMT targets, most of them high-income countries. Another major challenge was reaching people in prisons, Ms Mahy noted: only 11 countries had harm reduction programmes in at least one prison. Beyond that, PrEP was mostly inaccessible: only 27 countries (15 of them high-income countries) were offering PrEP to people who use drugs in 2023. In closing, Ms Mahy stressed the need to collect, provide and use relevant data, including community-led monitoring data, so HIV responses for people who use drugs can be grounded more firmly in public health principles.

16. Umunyana Rugege, Team Lead, Communities & Human Rights ai, UNAIDS, said it was important to understand the legal, policy and social environments in which people

seek healthcare. In 2025, 152 countries criminalized possession of small amounts of drugs for personal use (only 29 countries did not), while 112 countries recognized harm reduction in national policy documents, she told the PCB. However, the challenge was to put those policies into practice. She said new guidance from UNAIDS, the UN Development Programme (UNDP) and the International Network of People who Use Drugs (INPUD) showed that the criminalization of drug use and possession of needles was associated with higher HIV incidence and prevalence and with lower engagement in health services. Removing those punitive approaches was important for the success of public health programmes, she said.

17. Punitive legal and policy environments reinforced violence, discrimination and exclusion, she added. Some 35% of people who inject drugs reported experiencing stigma and discrimination in the previous six months (16 reporting countries); 23% said they had experienced physical or sexual violence in the past year (18 reporting countries); and 17% said they had avoided seeking healthcare due to stigma and for fear of being reported to the police or being forced into treatment (23 reporting countries). People who inject drugs faced many intersecting and compounding forms for discrimination, Ms Rugege explained, with the women among them especially vulnerable to violence and other dangers. Young people were often also excluded from harm reduction services and were targeted instead with abstinence approaches.

18. Many people who inject drugs lack trust in formal institutions, she said, but organizations led by their peers can reach them in trusted and nonjudgemental ways that reflect their realities and are more likely to meet their needs. She shared examples of such projects from India, Indonesia, Ukraine and Latin America and the Caribbean.

19. Turning to the issue of sustainability, Ms Rugege said less than 1% of HIV spending went to interventions for people who inject drugs, with donor funding for harm reduction having halved in real value in 2007–2022. In 2023, approximately US$151 million was available, compared with a projected need of US$1.5 billion by 2030. She highlighted examples of approaches to strengthening domestic financing and integration, including South Africa, where municipal financing supports community-linked harm reduction delivery, and Albania, where OAMT was integrated into the public health system and transitioned towards domestic financing from 2023.

20. Speaking from the floor, participants thanked the presenters for an informative session. They agreed that people who inject drugs bear disproportionate burdens of HIV, hepatitis C and other preventable harms, with stigma and discrimination, criminalization and other barriers preventing them from accessing health services. They highlighted the need to address the compounded discrimination and inequalities experienced by women who use drugs.

21. Harm reduction was an essential part of a people-centred and rights-based HIV response and was backed by strong evidence, speakers told the meeting. It protects the health and human dignity of people who use drugs and advances public health objectives. Yet availability and access were far below need. Speakers called on countries to remove structural and other barriers so people can safely access HIV and other health services. They emphasized the importance of community leadership and said community organizations were best placed to reach affected populations, provide trusted services, identify barriers, and achieve accountability. Noting that stronger data were needed to render people who use drugs more visible in national planning, speakers said increased use of community-generated data could help close some of the current data gaps.

22. Some country representatives (e.g. India, Iran and Mexico) described policy changes

and programmes they had introduced or were considering introducing, including the provision of harm reduction services in some prisons. Long-acting ARVs were an important option for people who inject drugs, speakers noted, and could be integrated into health systems along with existing tools for harm reduction and community engagement. Primary healthcare professionals were key to that process.

23. Speakers said they were especially concerned by the financing picture. At a time of severe pressure on global health and HIV financing, services for key populations, including community-led harm reduction services, were very vulnerable to disruption. They appealed for increased domestic investment and further integration of HIV programmes into national health and social protection systems.

Panel 1: Addressing inequalities that prevent progress in the HIV response for people who use drugs

24. This session examined the impact of structural and social inequalities, including intersecting forms of discrimination and exclusion, and discussed how harm reduction services were adapting to the evolving needs of people who use drugs.

25. Kaumba Akuffo, human rights advocate and co-founder of Tithandizane Comfort Homes, in Zambia, said her country was experiencing a rise in crystal meth use, which was leading to greater exposure to HIV infection and other harms. Women were especially vulnerable. The affected people needed healthcare, protection, help and respect, she told the meeting. She thanked the Zambian Government and other partners for supporting the roll-out of the long-acting ARV lenacapavir to communities of people who use drugs but noted that more can be done. The world would not end AIDS by leaving behind the people who were at highest risk of HIV.

26. Ms Akuffo told the meeting that community-led organizations were more than service providers: they understood the difficulties people face, earned people's trust, connected them to healthcare and supported them with compassion. She called for increased investments in community-led organizations, expanded gender-responsive services, strengthened HIV/TB treatment and support, and greater involvement of people who use drugs in decisions that affect their lives, so they can be treated with dignity and compassion.

27. Alexei Lakhov, policy advisor at the European Network of People who Use Drugs, said he had been imprisoned 22 years earlier for drug-related offences but was now advising prison authorities on the introduction of harm reduction services. He told the meeting that shame and self-stigma did not protect people against drug overdoses. Against the backdrop of his own experiences with overdosing, he informed that his own country used to have more than 100 harm reduction organizations which in the course of the last years had been reduced to 10. Where methadone treatment had been outlawed, people were turning to home-cooked methadone. He said drug use occurred on a continuum—and the response must operate accordingly as a comprehensive set of services and tools. Harm reduction was a human right, he stressed, and should not be reserved for people who can prove they are trying to quit dugs. Naloxone (opioid overdose treatment) must also be easier to access, without a prescription. Even though the Global AIDS Strategy emphasized harm reduction as a key part of the HIV response, no country was meeting all the harm reduction targets, he said.

28. Álvaro Morales Aser, forensic psychologist specializing in psychopharmacology and substance abuse at the San Carlos Clinical Hospital, Spain, told the meeting that people who use drugs were not a homogenous group. They experienced intersecting

and layered forms of inequality, discrimination, violence and more, with criminalization, stigma and exclusion generating fear and vulnerability. He said fear degraded individual and public health, by discouraging health-seeking, undermining treatment, damaging mental health and pushing people away from services into invisibility.

29. Spain was experiencing shifts in drug use, with chemsex and related practices, including among gay men and other men who have sex with men, increasing substantially, he told the PCB. Citing examples of the stigmatization and discrimination experienced by people who use drugs when trying to access healthcare services, he said trust was the most important element. Trust was best built through community leadership that reaches people who have been excluded, provides culturally competent support, creates safer spaces, and conducts community-led monitoring to identify gaps which routine systems fail to detect. An HIV response built on fear would take the world nowhere, he said.

30. Tatyana Sleiman, former executive director of Skoun, in Lebanon, said people who use drugs faced similar issues across countries, but security and economic factors added layers of vulnerability. In Lebanon, she said, criminalization was a significant challenge, leading to overlapping forms of stigma, fear and discrimination. Stigma was also linked to poverty, displacement and other realities, including HIV status, gender identity, sexual orientation and mental health. Together, those intersecting vulnerabilities created substantial barriers to health and social protection. A major challenge in the Lebanese context, she said, was the fact that people who use drugs were not taking into account in the humanitarian response, further excluding them from support systems. One way of addressing this was by integrating harm reduction into the health system, but that requires also reducing the high levels of stigma among first responders and healthcare workers, which is often due to a lack of knowledge about substance use and harm reduction. The root cause of those multiple barriers was often criminalization, she said. As long as drug use remains criminalized, equitable access to healthcare would stay out of reach for people who use drugs.

31. Nara de Araujo, Director of Prevention and Social Reintegration in the National Secretariat for Drug Policy at Brazil's Ministry of Justice and Public Security, said drug policies in Brazil had previously been highly punitive, an approach which intersected with racial, social and gender prejudices and discrimination. In 2024, a Supreme Court ruling had effectively reclassified the possession of cannabis for personal use from a criminal to an administrative offense, she told the meeting. The Court had called on the executive branch to advance prevention programmes and administrative measures to move beyond a punitive framework towards a more comprehensive health-centred model. The ruling had also unlocked access to funding for changes in drug policy. This allowed for the implementation of Centres for Access to Rights and Social Inclusion, a community-based service that seeks to connect excluded communities to healthcare, social care, legal assistance and other support in order to expand their access to services and help address the impact of historical injustices.

32. The moderator then asked panelists about the roles of communities. Ms Akuffo said they were central to finding viable solutions because they understood people's struggles and realities and were trusted by their communities. Álvaro Morales Aser said communities could use their knowledge and compassion to improve access to services for people who use drugs, help institutions understand their realities, and introduce necessary interventions. Mr Lakhov agreed and said networks of people who use drugs kept harm reduction alive in criminalized communities, while Ms Sleiman emphasized that people who use drugs were also bearers of knowledge. She stressed that effective harm reduction cannot operate in a context of criminalization. Ms de Araujo said it was important for governments to involve community-led organizations in

harm reduction programmes, on national drug policy forums, in the development of national drug policy plans, and in data collection.

33. Speaking from the floor, participants stressed the over-arching importance of choosing a public health approach over solely punitive approaches, and of reducing stigma and discrimination against people who use drugs. They noted that women who use drugs were especially vulnerable to HIV and highlighted an overlooked aspect of harm reduction: the needs of trans and gender-diverse people who use drugs. The intersecting forms of discrimination experienced by those communities rendered them highly vulnerable to HIV and other threats and created steep barriers to care and other services. They said anti-gender movements were affecting community-led harm reduction services in different countries.

34. Speakers drew attention to the many barriers that block harm reduction, including criminalization, intense stigma and discrimination, and restrictions placed on community-led organizations. They urged governments to base their drug policies not on fear but on evidence, compassion and public health priorities, and called for the protection of human rights, effective action against stigma and discrimination, and strengthened integration of people-centred approaches. Community leadership should be at the centre of efforts, they said, and sustainable financing approaches should be adopted.

35. Multiple channels of outreach were needed, the PCB was told, including social network strategies, and mobile and digitally assisted services. Outreach and prevention work relied on an understanding of the diversity of people who use drugs and should not be limited to people who inject drugs: the boundaries between non-injecting and injecting drug use were fluid. Also highlighted was the need to consider interactions between drug use and HIV sexual transmission, the value of age-differentiated harm reduction services, the importance of mental health support, and the overlooked challenge of drug use and harm reduction in humanitarian settings. Speakers shared examples of how collaboration between the state and civil society can facilitate integrated harm reduction programmes (e.g. Ukraine). Noting the ongoing donor funding cuts, they called for carefully managed transitions to domestic state funding for harm reduction and for increased direct funding to community-led organizations. The transitions must be inclusive, they insisted.

36. Several speakers described the introduction of relevant interventions in their countries, including the collection of community-led data and evidence; the integration of harm reduction in national drug policies (e.g. Islamic Republic of Iran); locating needle and syringe programmes and opioid agonist maintenance therapy in public health clinics (e.g. Kenya); and linking OAMT recipients to ARV treatment (e.g. Ukraine). However, ongoing stigma and the effects of funding cuts were threatening harm reduction programmes, they warned. One country representative told the meeting that coercive measures applied against their country were undermining access to the commodities needed for harm reduction. Another country representative said their comprehensive approach comprised of free-of-charge, voluntary HIV and viral hepatitis testing and treatment, drug treatment and behaviour change communication had reduced HIV incidence among injecting drug users..

Panel 2: Protecting human rights through law and policy change

37. This session examined the importance of human rights- and public health-based laws and policies for achieving the Global AIDS Strategy goals for people who use drugs and the need to remove punitive sanctions for drug use and possession for personal use. Panelists discussed the evidence regarding the effects on HIV outcomes of

decriminalization of drug use, alternatives to punishment, and the role of the community of people who use drugs in advocacy and monitoring.

38. Jaime Urrego, Vice Minister of Health of Colombia, via video, said that the evolution of legislation and case law in his country had facilitated an approach that prioritizes human rights over punitive responses to drugs. After describing specific examples of laws upholding public health principles, he said Colombia was using public policy tools that incorporate HIV harm reduction as a cross-cutting component of the health system. That includes the introduction of the CAMAD strategy, a drug addiction medical care centre that served more than 280 000 people across 205 districts, with the distribution of hygiene supplies, prevention tools, naloxone to respond to drug overdoses, screening for HIV and sexually transmitted infections, and referrals for OAMT. There is also a focus on supporting the health of young people through timely access to health services.

39. Mandeep Dhaliwal, Director of the Prosperity and Well-being Hub at UNDP, said the evidence supporting harm reduction and rights-based approaches was strong. Criminalization constituted a structural barrier and increased HIV and other risks in several ways. In contrast, she said, decriminalization helped reduce stigma, facilitated harm reduction and access to HIV prevention and other health services. She explained that decriminalization, legalization and depenalization are distinct concepts. Whereas decriminalization removes personal use of drugs from criminal law or criminal penalties, depenalization maintains the criminalization of drug use but removes or reduces custodial or sanctions, while legalization permits certain forms of drug use within a defined legal framework.

40. She said that many current drug conventions dated to the 1960s, when the so-called “wars on drugs” had commenced, and allowed some flexibility for health-centered, non-punitive responses. New guidance developed by UNAIDS, UNDP and INPUD on the decriminalization of drug use in the context of HIV sought to use those flexibilities to decriminalize the possession, purchase, or cultivation of certain drugs for personal consumption. She said the 2026 Political Declaration on HIV/AIDS also calls for creating enabling legal environments by reviewing and reforming, as needed, laws which impede effective HIV responses.

41. Ms Dhaliwal told the PCB that the main principles for decriminalization in the context of HIV were: human rights; a public health-based approach; respect for bodily autonomy and voluntary engagement; nondiscrimination; meaningful participation of affected communities; accountability and social inclusion; and addressing stigma and discrimination. She said the guidance note included a roadmap for achieving enabling legal and policy environments. Policy design choices would decide the outcomes. Criminal penalties for personal drug use should be removed, she said, and the use of other laws for similar punitive purposes should be avoided. The policy should be reviewed regularly to check whether public health and human rights outcomes are being met.

42. Elsa Maia, Senior Officer in the General-Directorate for Intervention on Addictive Behaviours and Dependencies in Portugal’s Ministry of Health, told the meeting that criminalization increases stigma and discrimination, discourages people from seeking health and other services, and reinforces exclusion. Recalling Portugal’s experience with a reformed drug policy, she said the country had faced a major public health challenge linked to heroin use in the 1980s and 1990s, with HIV incidence rates among the highest in Europe. This had led to the development of a policy that emphasized public health, human rights and social inclusion. A key step had been the passing of a 2001 law which continued to prohibit drug use but downgraded it to an

administrative offence. Accompanying the law were other measures, including a new intervention model and strong investment in prevention, treatment, harm reduction, social reintegration, and recovery services.

43. A nationwide network of harm reduction interventions was introduced, including needle and syringe programmes, OAMT programmes, outreach teams, drop-in centres, drug consumption rooms and other community-based services. This helped reduce barriers to healthcare and social support. Twenty-five years later, the effects on the HIV response among people who use drugs were clear, said Ms Maia. Portugal had made strong progress against the global AIDS targets, including the 95–95–95 targets, and HIV infections associated with injecting drug use had declined sharply (they comprised less than 2% of new HIV infections currently, compared with over 50% in the late 1980s).

44. She said decriminalization—when combined with comprehensive harm reduction, social integration and recovery programmes—can help reduce barriers to HIV services, create better conditions for prevention, treatment and care, and contribute to a substantial decline to HIV infections associated with injecting drug use. But she added that success requires sustained investment in high-quality, person-centred services across the continuum of care, as well as reductions in stigma and discrimination, and the involvement of people who use drugs in the design, implementation and development of programmes.

45. Aniedi Akpan, Chairperson of the Drug Harm Reduction Advocacy Network and Executive Director of the Drug Free and the Preventive Healthcare Organization in Nigeria, told the meeting that criminalization of drugs created a culture of fear, reinforced stigma and discrimination, and fueled mistrust—making it difficult for HIV and other services to reach people who use drugs. Arrests, detention, extortion and humiliating treatment by law enforcement personnel further discourage people who use drugs from seeking heatlh services, he said. His organizations were advocating for de facto decriminalization by engaging with multiple stakeholders, including the national Human Rights Commission, to establish alternatives to the criminalization of drug possession and use.

46. Ardhany Suryadarma, National Policy Manager at Rumah Cemara in Indonesia, said that criminalization was a barrier to health and human rights and stopped people from seeking healthcare services. After describing the work of Rumah Cemara, he said Indonesia was amending its narcotics laws and nongovernmental organizations were working to ensure that the amendment results in actual change. He said a different paradigm was needed, one that views people who use drugs as human beings with rights. Decriminalization was often misunderstood as the endorsement of drug use, he said, when in fact it was aimed at ensuring that no-one loses their right to health because they use drugs.

47. Drug use patterns were changing dramatically across south-east Asia, leaving many national drug policies outdated, Mr Suryadarma told the PCB. Most still focused on punishment, even though the evidence showed that this approach did not halt drug use. New approaches, focused on mental health services, community support, and harm reduction, were needed. Reformed drug policies and decriminalization should be integral parts of public health policy and HIV responses, he advised. While noting a decline in the funding that is needed to drive policy changes, he reminded the meeting that it took time for the work of strong community organizations to change policies. Ultimately, he said, it was impossible to end AIDS as a public health threat if laws make people afraid to access HIV and other health services. Instead of seeking ways to punish people who use drugs, they should be finding ways to enable them to remain

healthy and alive and uphold their human rights, he said.

48. Verónica Russo, of the Latin American and Caribbean Network of People Who Use Drugs and the Argentine Network for the Rights and Assistance of People Living with HIV, told the PCB that criminalization of drug use remained prevalent in Latin America and the Caribbean, a region that was experiencing a 13% increase in new HIV infections. The lack of systematically implemented harm reduction programmes in several countries in the region was due largely to legislative gaps, she said. The evidence showed that fear of criminal penalties, and institutional stigma do not reduce drug use, but they do hinder early diagnosis and retention in health services. Criminalization nullified the effectiveness of prevention efforts, whereas harm reduction was a cost-effective health intervention endorsed by WHO.

49. Asked about the role of communities in law and policy reform, Ms Russo said they were crucial: progress against HIV in her region had originated with communities, and people who use drugs continued to produce the evidence, devise solutions and build mechanisms for decriminalization and harm reduction decriminalization. HIV responses cannot succeed with community involvement, she insisted, adding that community-led monitoring was not merely an exercise in participation, but an indispensable technical governance tool that identifies market failures, shortages of harm reduction supplies, and human rights violations which official systems fail to record. She called for direct, flexible funding to organizations led by people who use drugs.

50. Responding to the same question, Mr Suryadarma said communities contribute unique insights to policy development, monitor the implementation of legal and policy reforms, help reduce stigma, and ensure that drug policies achieve the desired objectives. Ms Maia said community engagement involves more than consultation: communities are essential to define drug policies and are important sources of information about realities “on the ground” and about which measures work and which do not. She explained that Portugal has a formal mechanism for community engagement which holds regular public consultations on key national documents, where community representatives can participate and contribute to policy development.

51. Speaking from the floor, participants thanked UNAIDS for convening the informative discussion. They said the evidence clearly showed the devastating consequences of punitive drug policies and restricted access to harm reduction. Yet, prohibition remained the standard system of drug control, despite having failed to reduce drug use, while producing massive, wasteful and deadly systems of incarceration and discrimination.

52. Speakers cited research showing that women who use drugs experience overlapping forms of criminalization, stigma and coercion that create fear, discourage engagement with health services, and increase their risk of violence and other harms. Those experiences erode women’s trust in health systems and undermine their abilities to make informed decisions about their bodies, pregnancies and overall health, speakers explained. Young people who use drugs were also exposed to the harms of unregulated drug markets, were deprived of information on how to stay safer around drugs, and afraid of seeking help for fear of arrest and a lifelong criminal record.

53. Needed instead are moves towards health and human rights-centered frameworks of drug harm control, the PCB was told. Drug dependence must be treated as a health condition, not a punishable offence. Punitive approaches to drug use undermine individual and public health, they said, while human rights-based approaches bring people into care. Speakers called on governments to align drug policies with

approaches that protect public health, uphold human rights, respect human dignity, and advance sustainable development. The evidence supported making harm reduction and decriminalization key features of drug policies, they said. These were efficient and effective tools to save lives and reduce HIV and viral hepatitis infections, speakers reiterated. Yet policymakers in many countries continued to ignore the evidence. Harm reduction suffered from chronic underinvestment and was now under even greater threat following recent cuts to global health funding, which were having devastating effects on community-led activities. Other challenges included changing drug markets, pressures on health systems and shortages of skilled health workers.

54. The meeting was reminded that the UN had a common position on drug use, which was based on experiences such as in Portugal. That position empowered UN Resident Coordinators to work with communities and countries to improve drug policies and bring them in line with human rights. Guidance had been developed and the tools and evidence existed to push for decriminalization and wider availability of and access to harm reduction. Key steps, speakers said, can include expunging criminal records for nonviolent drug offenses, rejecting interventions that use the threat of punishment to enforce abstinence, and redirecting drug-related funding from the criminal justice system to health and social services. They added that policies must address the intersecting identities and experiences of people who use drugs and urged that decriminalization guidance explicitly refer to trans and gender-diverse people among the marginalized communities disproportionately affected by punitive drug policies.

55. Speakers shared details about harm reduction efforts in their countries (e.g. Germany and Kenya), including in prisons, as well as lessons learned. Since the beginning of the AIDS epidemic, they said, affected communities had driven the HIV response, often in the face of hostility and criminalization. They cited examples of community-led organizations defending harm reduction programmes against funding cuts and campaigning for the decriminalization of drug use, including in Mexico, South Africa and Ukraine.

Sustainable financing for harm reduction

56. The session reviewed funding gaps and other financing challenges and focused on the long-term sustainability of harm reduction services. Catherine Cook, Executive Director of Harm Reduction International, presented an overview of the funding situation. After summarizing the benefits of harm reduction, she said that 112 countries currently included it in national policies. In 2025, 95 countries had at least one OAMT programme and 60 were providing OAMT in a least one prison, while needle and syringe programmes were operating in 93 countries and were available in prisons in 11 countries. However, coverage of those services was far below the global targets.

57. She told the PCB that harm reduction funding in 2024 amounted to only 6% of the estimated global need. Two thirds of the funding came from donors. Over the years, many bilateral donors had withdrawn their support from harm reduction, leaving country programmes heavily reliant on the Global Fund, which currently provided about three quarters of all donor funding for harm reduction. However, recent funding cuts and Global Fund reprioritization had badly affected those programmes, forcing many to close or reduce their services. Peer outreach and community-led services were hit hardest, along with advocacy for human rights-based interventions. Ms Cook told the meeting that modeling suggested that just one year of disrupted services could lead to almost 10 000 new HIV infections and more than 13 000 hepatitis C infections in just nine countries. Reminding the meeting that harm reduction was classified by WHO as a “tier 1” priority, she urged countries to not deprioritize it. Noting the ongoing roll-back of human rights, gender equality and civic space, she called for the protection

of communities and civil society organizations that provide and advocate for harm reduction.

58. Although some low- and middle-income countries were investing in harm reduction, they were few in number, Ms Cook said. Sustainable financing, she explained, required going beyond small grants and pilot projects and embedding harm reduction in public health budgets and in insurance and benefit packages, and having social contracting mechanisms so civil society providers can access funding. The benefits were well-documented, she said, citing evidence that, for every US$ 1 spent on a needle and syringe programme, over US$ 7 was saved on healthcare costs.

59. Ms Cook highlighted the importance of financial and programmatic data on harm reduction, which were becoming patchier, making it more difficult to identify and address gaps. She said integration was an opportunity, but it also brought risks. People who use drugs faced stigma, discrimination and criminalization, and often felt unsafe in standard healthcare settings. This underscored the need to preserve community-led services and peer workers as core elements of integrated harm reduction programmes.

60. She said it was encouraging to hear calls for moving away from punitive responses to public health-oriented ones. Governments had an opportunity to critically assess the vast amounts of money spent on drug law enforcement that did not achieve the stated aims, caused human rights violations and impeded HIV responses, said Ms Cook. Decriminalization could free up resources for health and harm reduction, she told the PCB. In closing, she highlighted several points: domestic investment was key, but donor support remained crucial during that transition; integration must expand access without diluting harm reduction; and decriminalization, community leadership, and disaggregated financial and programmatic data were crucial for building effective and accountable programmes.

61. Sha'ari Ngadiman, vice-chair of the Global Fund Country Coordinating Mechanism in Malaysia, said that social contracting had been used since the 1990s via grants to the country's National AIDS Council, which channeled resources to community organizations. The introduction of a harm reduction programme in 2005 had marked a major policy shift. Financed by the Government and implemented by private healthcare providers and community organizations, the programme was expanded in 2011, after which the Government increased domestic investment and began replacing Global Fund support with national resources.

62. Harm reduction was also integrated into primary healthcare and the broader health system, which improved efficiency and sustainability, Mr Ngadiman said. A national harm reduction task force was set up, bringing together law enforcement agencies, correctional services, drug intervention services, civil society and development partners. That enabled Malaysia to expand OAMT services into some prisons and drug rehabilitation centres, thereby demonstrating that public health and public safety can work together. Technical and other support from WHO and UNAIDS had enabled the country to strengthen its policies and programmes.

63. Mr Ngadiman said Malaysia's experience showed the importance of political commitment and evidence-based investment, that integration can strengthen sustainability, and that communities play indispensable roles. Sustainability, he added, was not just about replacing donor funding with domestic funding, but about building resilient systems to ensure that no one is left behind.

64. Andrew Scheibe, of the University of Pretoria and TB HIV Care, South Africa,

reminded the meeting that South Africa still had the world's biggest AIDS epidemic, with people who inject drugs experiencing disproportionately high rates of new infections. More HIV services for this key populations were being introduced, mostly with donor funding, enabling OAMT and needle and syringe programmes to reach about 34 000 people who inject drugs. Service coverage, however, was far short of what was needed.

65. In the city of Tshwane, harm reduction services were being provided through a collaboration between the municipal government and the University of Pretoria's Department of Medicine, Mr Scheibe said. As South Africa's only municipally funded harm reduction programme, it was an example of how legal, policy and social challenges can be overcome. In 2025, the programme engaged over 128 000 people, distributed over 400 000 needles, and supported around 1,000 people on OAMT, in addition to providing psychosocial and medical services. The programme employed people with lived experiences of drug use, and it worked with the South African Network of People Who Use Drugs and other organizations. It also engaged the Department of Correctional Services to increase awareness of harm reduction, though such services were not yet available in prisons. The programme's reliance on funding from local government, however, meant its sustainability was not guaranteed. At national level, he said, there was some progress towards sustainable funding for OAMT. A small national Department of Health pilot project was underway to integrate methadone treatment in primary healthcare. It was hoped that the project could provide data and other evidence for the expansion of similar services.

66. Ganna Dovbakh, Executive Director, Eurasian Harm Reduction Association, told the meeting that the previous 30 years had seen much wider recognition of harm reduction emerge in Eastern Europe and Central Asia. However, governments seemed more willing to fund the medical elements of harm reduction than the social components. Integration of OAMT and broader harm reduction with mental health was also progressing across the region, and there was growing recognition of the need for outreach workers, community navigators, peer supporters and community-led organizations. Community-led harm reduction can be made sustainable, Ms Dovbakh said, through state procurement of services, especially via social contracting mechanisms. Czechia, Estonia, Lithuania, North Macedonia, Polandand Ukraine were showing that sustainable public investments in harm reduction were possible.

67. Not all integration efforts had been successful, she said, especially those that did not involve organized communities: capable, strong community organizations were needed for integration to work. She told the PCB that the most sustainable approach was to fund community-led organizations directly through public budgets and emphasized the importance of catalytic funding from the Global Fund and support from the Robert Carr Fund and the Elton John AIDS Foundation for sustaining community networks, community-led monitoring and advocacy. Harm reduction could not be sustained without investments in community organizations.

68. Asked about the impact of legal restrictions, Ms Dovbakh described the ways in which so-called "foreign agent" laws were stifling community organizations and harm reduction in her region. Since governments do not fund the advocacy activities of community organizations, external funding had to be sought, which could lead to an organization being designated a "foreign agent". "Drug propaganda" laws could have a similar, restrictive impact, she said.

69. Mr Scheibe was asked about implementation challenges for integrating harm reduction into public health systems. He said it was difficult to have person-centred services in systems that were over-stretched. In addition, stigma and discrimination from health

and social services providers could discourage uptake of services and reduce the quality of care. Healthcare workers needed training on harm reduction and substance use to counter misconceptions and they must understand which approaches work, he said. The capacity of healthcare workforces was also an ongoing issue. Ultimately, effective integration needed strong partnerships between governments and community-led organizations.

70. Mr Ngadiman was asked what factors tend to favour the acceptance of harm reduction as part of a national HIV response. He said that rather than view public health and law enforcement as competing priorities, it was important to establish common ground and show that the protection of public safety and public health was compatible. Even where legal frameworks were not entirely aligned with public health policy, common ground was still possible, he insisted. In Malaysia, a multisectoral approach, led by strong leadership from the Ministry of Health, and involving law enforcement agencies, religious leaders, civil society organizations and communities, had helped build trust and understanding. The focus had been on reducing HIV transmission and achieving public health benefits, he explained. Continuous advocacy and sharing of scientific evidence had shown that harm reduction did not encourage drug use but did increase the use of health services that improve people's health and well-being. Gradually, this had allowed for some interventions to be implemented even while legal reforms were still evolving. Engagement with multiple ministries had led to the expansion of OAMT.

71. A major lesson, said Mr Ngadiman, was that, while enabling laws and policies remained important, it was not always necessary to wait for comprehensive legal reforms: progress could be made by identifying practical opportunities for collaboration, building trust across sectors, and focusing on shared, desired outcomes. Another lesson was that communities were indispensable partners for reaching under-served populations and making interventions more equitable, effective and people centred. He said change was rarely achieved overnight, but was built through trust, partnerships and the common understanding that everyone benefits when public health is protected.

72. Speaking from the floor, participants thanked the panelists for an insightful discussion. They underscored the concerns raised about the use of “foreign agent” and other restrictive laws, and shared details about specific restrictions that were being introduced in their countries. Speakers commended UNAIDS, UNODC, UNDP and WHO for their normative support and welcomed the latest WHO guidance on needle and syringe programmes. The evidence showed that needle and syringe programmes, OAMT and naloxone overdose services worked and were good value for money, they said, but coverage remained poor. While broadly supportive of integration, they cautioned that it should not make it harder for people to access services, and they reiterated that community-led organizations were vital for providing safe and trusted services.

73. Speakers emphasized the importance of sustainable financing and strategic information. They cautioned that data on the availability of harm reduction services usually signified that at least one site in a country was providing harm reduction; it did not imply wide coverage. In addition, they said, harm reduction interventions were very fragile and tended to be sacrificed during funding cuts, humanitarian crises or political changes. Citing the example of Ontario province, in Canada, they said hard-won gains can be undone in a single budget cycle: supervised drug consumption sites had prevented over 20 000 fatal overdoses and made over half a million HIV- and other health-related service referrals, yet political pressure and growing misinformation are now leading to the defunding of those spaces. This underscored the need for a strong Joint Programme to continue advocating for equitable access to harm reduction,

countries to strengthen domestic policies, cosponsors to provide technical assistance and civil society to have adequate support and resources to make these programmes resilient, the meeting was told.

74. Speakers also said that realizing the potential of long-acting ARVs and people-centred integration required dealing with barriers such as criminalization, punitive law enforcement approaches, and stigma and discrimination. Reiterating that the Global Fund remained a key supporter of health interventions for people who use drugs, they urged countries to fight misinformation, strengthen their domestic policies and support equitable access, and they called on the Joint Programme to continue providing technical support and guidance.

Closing—Conclusion and ways forward

75. Angeli Achrekar, UNAIDS Deputy Executive Director, thanked the panelists and facilitators for the session and said that ending AIDS meant that no one is left behind. She said that progress in expanding access to harm reduction had been far too limited and stressed that ending AIDS as a public health threat required reaching 90% of people who inject drugs with a combination of effective HIV prevention options, including comprehensive harm reduction services. She recounted several themes that had emerged during the discussion. Firstly, people who use drugs are not a homogenous group, she said, but comprise diverse communities who face overlapping and intersecting conditions. Secondly, criminalization remains one of the biggest barriers blocking the protection of their health. Thirdly, financing for harm reduction is at great risk. And, fourthly, community-led responses are central to building trust, advancing policy changes and delivering effective harm reduction services and must be institutionalized and sustainably funded.

76. Ms Achrekar said harm reduction responses must be tailored to the varied realities of people who use drugs, and countries must move away from criminal sanctions for drug use in favour of public health and human rights-based approaches. Also important is the integration harm reduction into national health frameworks and the use of social contracting to boost public financing for community organizations. In closing, she highlighted the need for strengthened and protected community leadership, and for improved data collection and use, including from communities themselves and translate the commitments of the new Political Declaration into action.

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