1 December 2022

NEGOTIATIONS ON THE CONCEPTUAL ZERO DRAFT OF AN INTERNATIONAL INSTRUMENT ON PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE

The **International Network of People who Use Drugs (INPUD)** is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD seeks to expose and challenge stigma, discrimination, and the criminalisation of people who use drugs along with the impacts these have on health, rights and dignity of communities of people who use drugs globally.

Currently a process is underway to negotiate a new international instrument on pandemic prevention, preparedness and response (PPPR). On 5-7 December 2022, the Intergovernmental Negotiating Body [INB] (constituted by WHO member states), will meet in Geneva, Switzerland to discuss the recently released 'Conceptual Zero Draft of the New International Instrument on PPR'. This statement is a response to the proposed new instrument from INPUD on behalf of people who use drugs globally and is informed by recent community-led research on PPPR among our networks and communities, as well as research conducted by INPUD during the Covid-19 pandemic[1].

The key issues and recommendations in this statement are focussed on the following areas: impacts of marginalisation and criminalisation; support for community-led and peer-based responses; strengthening policy and service delivery responses and community engagement and accountability.

Impacts of Marginalisation & Criminalisation:

For communities of people who use drugs, the Covid-19 pandemic brought unprecedented challenges and not only created new vulnerabilities but exacerbating existing ones. In this context, people who use drugs have experienced unique risks and disproportionate burdens due to criminalisation and its impacts. These included stigma and discrimination, rights violations, exacerbated health problems, barriers to health care access, increased surveillance and policing, punitive approaches to enforcement measures, social marginalisation and higher economic and social vulnerabilities[2]. Additionally, for people who use drugs and other key populations, the disproportionate impacts extend to managing the ongoing effects of multiple pandemics on these communities including Covid-19, HIV/AIDS and viral hepatitis, etc. While INPUD welcomes the recognition of principles of human rights and the right to health, as well as specific references to vulnerable and marginalised communities across the Conceptual Zero Draft, we believe it is necessary to also to make specific reference to **'criminalised communities'** due to the unequal and disproportionate impacts of the Covid-19 pandemic for these communities. For example, people who use drugs were at greater risk of being arrested and harassed in public places particularly

[1] Covid-19 Survey Reports: Health & Rights of People Who Use Drugs in a Pandemic Environment can be found on the INPUD website at: https://inpud.net/Covid-19-survey-reports-health-rights-people-who-use-drugs-Covid-19-environment/
[2] See above Covid-19 Survey Data Reports 1 & 2

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people who were homeless or street involved. Criminalisation also entrenches poverty and during lockdowns people who use drugs were often forced to choose between livelihood and protection of health. Moreover, due to criminalisation, people who use drugs are often fearful of accessing health services due to likelihood of discrimination and punitive responses and therefore, had less access to essential health information. In addition to these impacts, many people who use drugs do not just experience significant levels of ongoing stigma and discrimination and human rights violations in response to their actual or perceived use of drugs, but often are also dealing with the additional burdens associated with intersectional discrimination.

Recommendations:

1. Given the ongoing and unacceptable impacts of criminalisation on the health, rights and dignity of people who use drugs, INPUD believes that decriminalisation and wider drug policy reform must be a core part of pandemic prevention, preparedness and response efforts and therfore call on the INB to specifically include a commitment towards drug decriminalisation in this proposed instrument.

2. Add specific references to ***criminalised communities*** and groups targeted by unjust criminalisation such as people who use drugs, sex workers, transgender people and gay men and men who have sex with men (MSM) to the current draft including:

   a. ***Article 4 (12)*** – "Non-discrimination and respect for diversity – All individuals should have fair, equitable and timely access to pandemic response products and health services, without fear of discrimination or distinction based on race, religion, political belief or economic or social condition." **INPUD believes this clause needs to be broadened to ensure that criminalised communities are protected and that the role of criminalisation in driving discrimination and marginalisation in the context of pandemic preparedness and response is recognised.**

   b. ***Article 4 (13)*** – "Rights of individuals and groups at higher risk and in vulnerable situations – Nationally determined and prioritized actions, including support, will take into account communities and persons in vulnerable situations, places and ecosystems. Indigenous peoples, refugees, migrants, asylum seekers, and stateless persons, persons in humanitarian settings and fragile contexts, marginalized **[and criminalised]** communities, the elderly, persons with disabilities, persons with health conditions, pregnant women, infants, children and adolescents, for example, are particularly impacted by pandemics, owing to social and economic inequities, as well as legal and regulatory barriers that may prevent them from accessing health services".

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c. ***Article 14 (2) (b)*** – "Tackle the ***social, environmental and economic determinants of health*** that contribute to the emergence and spread of pandemics, and prevent or mitigate the socioeconomic impacts of pandemics, including but not limited to, those affecting economic growth, the environment, employment, trade, transport, gender equality, education, social assistance, housing, food insecurity, nutrition and culture, and especially for persons in vulnerable situations **[and criminalised communities].**"

d. ***Article 14 (2) (d)*** – "Strengthen ***national public health and social policies to facilitate a rapid, resilient response***, especially for persons in vulnerable situations **[and criminalised communities].**"

Support for Community-Led & Peer-Based Responses:

The Covid-19 pandemic demonstrated what we knew already from other epidemics such as HIV: that community-led networks and peer-based services are a crucial part of pandemic prevention, preparedness and response, both for their ability to adapt and rapidly meet the emerging needs of communities and for providing health information to 'hard-to-reach' communities, for linkage to health services, for mutual and emergency aid, and for mental health and psychosocial support[3]. At the global level, the importance of community-led organisations and peer-based services are increasingly being acknowledged with formal commitments towards increasing the proportion of HIV services delivered by communities enshrined in the '30-80-60' targets of the Global AIDS Strategy (2021–2026)[4].

Community-led service delivery platforms are often more effective than formal health facilities in reaching marginalised and criminalised communities particularly in the context of ongoing stigma and discrimination[5]. Community-led and peer-based services are also recognised as an effective way to ensure that limited public health funding makes to the people and places where it is needed most. For example, during the Covid-19 pandemic, peer-based services run by and for people who use drugs were able to mobilise quickly to develop peer resources and educational materials, produce policy statements and guidelines and provide direct outreach services[6]. In this context,

[3] Funders Concerned About AIDS. 2022. Philanthropic Support to Address HIV and AIDS in 2020. FCAA. Washington DC.pp.51-55. https://www.fcaaids.org/inform/philanthropic-support-to-address-hiv-aids/

[4] Global AIDS Strategy 2021–2026: End inequalities, end AIDS. Geneva: UNAIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf)

[5] Funders Concerned About AIDS. 2021. Making the Case for Greater Investment in Community Rooted Funders. FCAA. Washington DC. https://www.fcaaids.org/community-rooted-funders/

[6] International Network of People who Use Drugs (INPUD). (2020a). *COVID-19 Crisis: Harm reduction resources for people who use drugs*. Retrieved from: https://www.inpud.net/en/Covid-19-crisis-harm-reduction-resources-people-who-use-drugs.

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instead of being an afterthought the work of community-led and peer-based organisations and services needs to be a centralised part of PPPR so that countries are ready to respond in the future and can work in partnership with key communities.

Access to Essential Services

Harm reduction services including Needle and Syringe Programmes (NSPs), Opioid Agonist Therapy (OAT), naloxone distribution and safe consumption rooms/overdose prevention sites are recognised as essential components of the right to health[7]. During the Covid-19 pandemic, where they exist, harm reduction services were recognised as essential services and for the most part, remained available. Significant work remains to be done, however, to both expand resourcing for and access to essential harm reduction services in many contexts (where they are not yet available or adequately accessible) and, to ensure that these services remain available and continue to be recognised as 'essential services' in the context of PPPR and beyond.

In many contexts, harm reduction services for people who use drugs, are based on community-led or peer-based service models. Research undertaken by INPUD during the first year of the Covid-19 pandemic and again, in late 2022, also highlights the importance of community-led and peer-based services for people who use drugs in the context of global emergencies. Specifically, INPUD's research highlights that it was community-led and peer-based health services that communities were able to rely upon for their essential health needs. This was particularly so, when many large public and private health services went into lockdown, closed their doors and/or took their services online (a particular problem for communities such as people who use drugs who typically have poor or no access to data and technology). Put simply, community-led and peer-based services are effective because the peer workforce knows what the community needs and how to meet those needs in ways that are accessible, safe, trusted and non-judgmental – always important, but even more so, during times of additional stress and vulnerability.

Financing for Community-led Responses

Despite the critical role played by community-led and peer-based services during the Covid-19 pandemic, community-led and peer-based services remain chronically under-resourced. Estimates INPUD's research also highlights significant weaknesses and problems with existing financing mechanisms which do not sufficiently value or recognise the expert knowledge within communities. As stated above, communities know what needs to be done but existing financing mechanisms often do not make best use of or allow for this expertise in the funding process. Instead, communities spoke of delays and overly bureaucratic, complex and inflexible funding mechanisms that are creating a great deal of additional and unnecessary pressure for already under-resourced community-led organisations and networks on the frontlines of responses to pandemics and other emergencies. INPUD believes this is an opportunity to ensure these issues are addressed and to

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[7] Letter to the Special Rapporteur on the right to the highest attainable standard of physical and mental health on protecting and promoting the health of people who use drugs during the COVID-19 emergency, 31 March 2020 accessed at: [Right_to_health_of_people_who_use_drugs_-_COVID19_(31_March_2020).pdf]

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strengthen the capacity, resourcing and support for community-led organisations and for the peer-led workforce in the context of PPPR and as a core aspect of PPPR response going forward.

Recommendations:

1. ***Article 11: Strengthening and sustaining a skilled and competent health workforce***
   "The Parties [shall]/[should] strengthen and sustain an adequate, skilled, trained, competent and committed health workforce **[Add: including community-led and peer-based workforces]**, with due protection of their employment, civil and human rights and well-being, consistent with relevant codes of practice, including at the frontline of pandemic prevention, preparedness, response and recovery of the health system. "

2. ***Article 18: Sustainable and Predictable Financing*** – INPUD believes this clause needs to specifically address the financing needs of marginalised and criminalised communities (and the community-led and peer-based services upon which they rely) to ensure that available funding is not only received in a timely manner but is also going to those who need it most.

Strengthening Policy and Service Delivery Responses:

Innovation Not Just 'Continuity'

One of the key lessons from the Covid-19 pandemic in relation to people who use drugs is that 'ensuring continuity of primary care' should not be the only agenda in relation to preventing, preparing and responding to future pandemics and other emergencies. Indeed, the Covid-19 pandemic also highlights the importance of taking up the opportunities presented by pandemics and other emergencies to improve access to care and strengthen policy responses. For example, during the Covid-19 Pandemic, flexibilities in OAT access including greater take home doses, home dosing, no supervised/'in-clinic' dosing, no urine testing, etc., were made possible for people on OAT when they had previously been told that such policy changes were impossible because they were too risky. Far from negative outcomes or risks being realised, research with people who use drugs has revealed overwhelmingly positive outcomes and as a result, many countries have decided to retain these more flexible policy approaches.

In addition to opportunities to create more flexible and responsive models of care, the Covid-19 pandemic also witnessed a massive shift towards online environments as a way to keep essential information and services available in a pandemic environment. As raised above, however, although digitization during the Covid-19 pandemic was both an important way to enable access to information and community support, people who use drugs were also negatively impacted by the digital divide including a lack of access to technology and data. Thus, INPUD strongly suggests that issues related to the digital divide and access to technology needs to be addressed in order to ensure access to services and information in the context of PPPR.

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In the context of the two examples outlined above, INPUD believes that the political and social realities presented by pandemics and other emergencies should not be viewed as fixed situations, but rather emergent eventualities and therefore open to change. Specifically, in relation to communities of people who use drugs, the Covid-19 pandemic has opened opportunities to rethink the function of punishment and punitive responses, by looking instead towards the benefits of system reform and ending criminalisation and its many harmful impacts[8].

Recommendations:

1. ***Article 10*** **Strengthening and sustaining preparedness and health systems resilience**
   Article 10(2)(b)(i) – **"**measures to ensure continuity of primary health care and universal health coverage by maintaining the availability of, and timely access to, efficacious, quality, safe, effective, affordable and equitable health services, including clinical and mental health care"

2. While INPUD supports the above clause, we also believe this proposed instrument and the process involved presents a much wider opportunity to enshrine a greater sense of the 'possibility of change, reform and positive outcomes' into PPRR and therefore recommends the addition of language in this clause and across the proposed instrument as a whole, that encourages policy reform not merely "continuity".

Safeguarding Access to Essential Medicines & Stock-Ups

The right to health, and the right to life, require that people have access to essential, life-saving medicines. People who use drugs are vulnerable to HIV, tuberculosis (TB) and hepatitis as well as overdose. Thus, ongoing access to medicines including anti-retroviral treatment for people living with HIV/AIDS, anti-TB drugs including second-line treatment, directly acting antiviral drugs for hepatitis C, naloxone for people who use opioids and Opioid Agonist Treatment (OAT) medicines including methadone and buprenorphine are essential in maintaining the health of vulnerable populations. In times where access to health and harm reduction services may be disrupted, the ability to stock-up on these medicines is essential. INPUD believes therefore that the proposed instrument must adopt the necessary measures to ensure that the international supply chains of these essential medicines are not disrupted including the maintenance of sufficient buffer stocks.

During Covid-19 pandemic and in other recent national emergencies (incl. wars/conflicts), however, INPUD is aware of communities of people who use drugs who have experienced stockouts of essential medicines such as Opioid Agonist Treatment (OAT) medications even when communities have tried to warn states of the potential for stockouts early in the pandemic or other emergencies. Ongoing and entrenched stigma and discrimination associated with criminalisation, however, has frequently meant that the voices and concerns of these communities have not been heard.

[8] Chang J, Agliata J, Guarinieri M. COVID-19 - Enacting a 'new normal' for people who use drugs. Int J Drug Policy. 2020 Sep;83:102832. doi: 10.1016/j.drugpo.2020.102832. Epub 2020 Jul 3. PMID: 32654930; PMCID: PMC7332951.

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Recommendations:

1. Due to the concerns outlined above, ***Article 6(2)(c)*** "enhance countries' and regional logistical capacities to ***establish and maintain strategic stockpiles*** of pandemic response products" must also include specific reference to greater meaningful engagement with marginalised and criminalised communities to ensure they are at the policy table and their essential health needs are met.

2. It is recommended to add a clause to the current ***Article 6*** that: "States should utilise simplified control procedures for the export, transportation, storage and provision of medicines containing controlled substances, in order to ensure people can maintain consistent access to these medicines and an avoid serious health consequences."[9]

Women Who Use Drugs and Gender Based Violence

Around a third of all people who use drugs are estimated to be women. Women who use drugs are consistently reported to be at higher risk of HIV and hepatitis C infection than men who use drugs, while having less access to harm reduction services. Women who use drugs need ongoing access to non-judgemental sexual and reproductive health services. The intersecting stigma attached to gender and to drug use means that women who use drugs endure heightened levels of stigma and discrimination. This phenomenon is likely to be exacerbated in a context of heightened isolation and stress. Indeed, there is now growing data showing the increases in gender-based violence during the Covid-19 pandemic, as well as during other emergencies[10]. It is thus essential that support services for victims/survivors of gender-based violence are available during pandemics and other emergencies, able to respond to the needs of women and equipped to remain effective in these circumstances. Furthermore, recent research conducted by INPUD in relation to PPPR, has specifically identified gender-based violence as a significant issue for women and gender diverse people who use drugs during the Covid-19 pandemic[11].

Recommendations:

1. While INPUD welcomes the inclusion of ***Article 13 (2)(c)(ii)(a)*** addressing "measures to gather and analyse data, including data disaggregated by gender" we also believe that more work needs to be done on better understanding the relationship between certain policy responses (specifically criminalisation) and gender-based violence. We therefore encourage

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[9] See: www.unodc.org/romena/en/Stories/2020/August/incb--who-and-unodc-statement-on-access-to-internationally-controlled-medicines-during-covid-19-pandemic.html

[10] See: UN Women – The Shadow Pandemic: Violence Against Women During Covid-19: https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-Covid-19-response/violence-against-women-during-Covid-19 and UNFPA ESARO.2022. Gender Based Violence and Covid-19 – Actions, Gaps and the Way Forward. UNFPA ESARO. https://esaro.unfpa.org/en/publications/gender-based-violence-and-Covid-19

[11] Preliminary findings – Research Report available January 2023.

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the inclusion of a specific reference to **“criminalised communities”** in the clause following the statement about “the impact of policies on different groups.”

2. INPUD also believes an additional clause should be added to specifically ensure funding and services for victims/survivors of gender-based violence are a central aspect of PPPR.

Community Engagement and Accountability:

The right to health includes the right of communities to participate in decisions that affect their health and wellbeing[12]. In this context, INPUD strongly believes that meaningful participation and involvement of communities and accountability to communities should be reflected in all aspects of pandemic prevention, preparedness and response, including this instrument and the processes involved in its development. It should be noted that this should include engagement by and with communities in processes at both the national and global levels. The lack of proper, meaningful involvement of key communities, including key populations, in the PPPR negotiations, not only removes important knowledge and expertise from the process, but risks criminalised communities such as people who use drugs being ‘left behind’ and structural inequities being perpetuated into the future. In short, INPUD believes that meaningful community participation in PPPR is not just a ‘nice to have’ or an ‘optional extra’, it is the difference between a closed process and one that is fundamentally democratic and open. In this regard, INPUD adds its voice to the calls by other community-led and wider civil society organisations to address the fact that currently there is no official channel for community and civil society participation in the instrument’s development. Furthermore, INPUD also supports wider calls for the greater inclusion of principles of accountability to be properly embedded in the current instrument.

Recommendations:

1. **Article 15 (2) – Community engagement and whole-of-society actions** – While we recognise and welcome the references to “community engagement”, “meaningful participation”, “community empowerment” and “feedback mechanisms”, beyond these concepts, INPUD believes consideration should be given to the value and potential role of community-led monitoring (CLM) approaches. To this end, CLM should not only be included for assessment and monitoring purposes but also as an important governance and accountability mechanism particularly as anti-corruption measure. CLM also needs to be adequately resourced and supported.

2. INPUD urges the INB to immediately address the absence of an official channel for community and civil society participation in this current process of negotiation and development towards a future PPPR instrument.

[12] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12), 11 August 2000, UN Doc. E/C.12/2000/4.

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In conclusion, effective pandemic prevention, preparedness and responses (PPPR) hinge on strong community systems and responses in reaching those who aren't served by formal health systems. If health responses work for the most vulnerable and criminalised communities, then they will work for all. 'Putting the last mile first' is a key principle of Universal Health Coverage (UHC) and should therefore be the driving principle of future pandemic prevention, preparedness and responses (PPPR).