INPUD International Network *of* People *who* Use Drugs

POSITION PAPER

Integration Without Erasure: Preventing the **disintegration** of community-led responses to HIV, TB and other health challenges

Position Paper
April 2026

"Community-led services are not a temporary solution, to be absorbed and phased out. They are a permanent, essential part of effective and rights-based health systems. Integration that weakens peer leadership, cuts harm reduction, or sidelines drug user-led organisations is not progress, it is regression. We must ensure that integration happens with us, not to us."

Anton Basenko, Executive Director, INPUD

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Background

Many governments, funders and United Nations (UN) agencies are pushing for the rapid ***integration*** of HIV, TB and malaria (HTM) efforts into primary health care (PHC) and broader health systems. As people who use drugs, we are a "key population" heavily affected by HIV and TB. Our health, our rights, and our lives are at stake in how integration is defined and how it is done. For the response to these epidemics to be effective and sustainable, it must be informed by our expertise—including that which comes from lived experience—and we must be meaningfully involved in shaping the response, including how integration is implemented. This is an ethical obligation, a human rights obligation, and a pragmatic reality. But there is the very real risk that, yet again, we will be left behind, and that the policies, programs and services we need to protect and promote our health will be ignored, sidelined or excluded.

> This document presents INPUD's calls to action aimed at minimising the risks of integration being done poorly and maximising the potential for it to benefit people who use drugs.

The primary focus here is on integration at the level of *service delivery*. This is the context in which most people interact with the health system. However, there are various other components to a health system (e.g., the workforce, both paid and volunteer; laboratory and other diagnostic systems; systems for gathering and using information to guide decisions; supply chains for all the products needed by the health system; community organisations and workers; mechanisms and strategies for financing the health system).[1] Health systems also operate within larger legal, political and social contexts. Therefore, the push to integrate HTM efforts with broader health systems has implications, and requires action, beyond just the point of service delivery and beyond the health system itself. Failure to address these will undermine successful integration. This position paper identifies some of the most important issues that must be addressed in these other areas for integration to achieve the hoped-for benefits.

The need for a nuanced and phased approach to integration

The stated goals of integration are to strengthen health outcomes, improve a people-centered approach, and enhance efficiencies to advance the end of HIV, TB and malaria in a sustainable way.[2] This can help achieve "universal health coverage" (UHC), which means that all people receive the quality health services they need, when and where they need them, without suffering financial hardship. All countries agreed to try to achieve UHC by 2030, as one of the Sustainable Development Goals.[3]

But the demand to speed up integration is driven chiefly by donor countries' rapid, dramatic, and damaging funding cuts for global health. Integration is seen as a way to save money, whether by donors backtracking on commitments to global health or by national governments facing multiple health or other needs. Such cuts make it harder to achieve the end of HIV, TB and malaria epidemics as public health threats by 2030, which is another one of the Sustainable Development Goals.[4]

The *Global AIDS Strategy 2026-2031* identifies "integrated services," and the "integration of HIV interventions and HIV-related health and community systems with primary health care, broader health systems and key, non-health sectors," as top priorities in the next phase of the HIV response.[5] However, just as importantly, the new Global AIDS Strategy also identifies ensuring "community-led responses, rights-based and gender-responsive approaches and community-led governance" as other priorities.[6]

Similarly, the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund)—the largest, most important multilateral source of funding for responding to these three diseases—is also strongly pushing integration through its grants to eligible countries. But it also acknowledges that integration carries risks and costs, and that strategies must be adopted to mitigate those risks.[7]

Integration is necessary and, in some cases, good. Under the right circumstances, and when done thoughtfully and carefully, integration can lead to improved access to care, better health outcomes, better use of resources, and longer-term sustainability of services. But integration that is rushed and careless is a recipe for less access to care, especially for key populations such as people who use drugs. This means poorer health outcomes, wasted resources, and ultimately a response to HIV, TB and malaria that is less person-centred, less effective, and less sustainable.

A sensible approach is to advance integration *where it is necessary and reasonable*, with careful attention to the details, which matter for the health, lives and dignity of those whose access to services is at stake. But it is equally important to clearly recognise that integration is sometimes neither necessary nor reasonable—and in circumstances where it poses risks of significant harm, it should be rejected.

Concerns for people who use drugs

As people who use drugs, we have particular reason to be concerned about an ill-conceived and hastily executed rush to integration, driven by fewer resources, in the context of widespread stigma, discrimination, criminalisation and other infringements of human rights that we experience.

Falling through the funding cracks

Within the already-inadequately funded global HIV response, the lack of funding has been particularly pronounced when it comes to addressing HIV and viral hepatitis among people who use drugs. For example, the most recent analysis reports that, in 2022, funding for harm reduction programs accounted for less than 1% of total HIV funding, and harm reduction funding in low- and middle-income countries (LMICs), from both domestic and international sources, was only 6% of what is needed.[8] As of 2022, the Global Fund accounted for 73% of all *donor* funding for harm reduction, and many countries had no identifiable *domestic* funding for harm reduction programmes.[9]

As reported by Harm Reduction International, "the global harm reduction landscape has become increasingly fragile" in recent years.[10] The impact of rapid, drastic cuts in 2025 to US foreign aid on the health and well-being of people who use drugs "has been massive and monumental," including "significant disruption to core harm reduction services, HIV/Hepatitis C (HCV) programming, and commodity supplies for people who use drugs globally."[11] Other wealthy countries have also significantly cut funds committed to global health, including harm reduction. **In the absence of alternative measures to ensure the continuity of such services, and equitable access to them, as people who use drugs we are being erased from the HIV and HCV response.**[12]

Given the shrinking donor commitments to global health, there is a corresponding pressure for LMIC countries to increasingly fund their HTM responses themselves. This includes a push by the Global Fund, the single largest source of funding for harm reduction, for greater "national self-reliance" and "health sovereignty" by LMIC countries and to accelerate countries' transition out of eligibility for Global Fund grants. Health services for people who use drugs, including harm reduction, are particularly at risk in such a shift.

An effective, sustainable response to HIV, viral hepatitis and TB requires a substantial *scaling-up* of services in many settings, including in particular harm reduction and other services for people who use drugs. But some national governments are opposed to such services, despite the evidence and the public health and human rights imperative for them. Other governments simply do not care enough about harm reduction, in the face of greater demands on domestic budgets. In some instances, the services that exist may not be of sufficient scale (e.g., stalled at the 'pilot project' stage), may not be equitably accessible and/or meeting the needs of particular populations of people who use drugs, or may not be of good quality (e.g., unjustified limits on access to sterile injection equipment, interventions to treat drug dependence that are not evidence-based). In many instances, it will be easy and convenient to let such services, needed by a population that is heavily stigmatised and largely criminalised, fall by the wayside entirely or continue to be chronically underfunded and insufficient to meet the need.

This context heightens the risk that "integration" of HTM with broader health systems will result in the further erasure of people who use drugs from the response, as well as the ***disintegration*** of effective services and systems that have taken decades to build. In particular, it is *community-led* services that are even more important for enabling access, given the stigma, discrimination and criminalisation we experience.

Such outcomes from integration being poorly implemented would be directly at odds with the important goal of *strengthening* community-led organisations that is part of the *Global AIDS Strategy*.[13] This makes it all the more critical that integration of HTM into broader health systems, where it is necessary, be undertaken carefully, with a conscious commitment to our inclusion and welfare, such that it preserves and sustains harm reduction and other rights-based health services we need.

> If drug user-led organisations, networks, and service delivery are permitted to be the first to close because of lack of funding and political will, the entire harm reduction model and its systemic infrastructure is placed in significant jeopardy. The harm reduction model works only because of community-led responses. Peer educators and outreach is how we are able to reach our community. They are the bridge between the community and formal health services. Peer workers build the trust and relationships that allow us to change drug use practices, help get people into care and treatment, and build community strength, leadership, and resilience.[14]

Absence of an 'enabling environment'

In addition to insufficient funding, legal and social environments that criminalise and stigmatise key populations, or that restrict space for civil society organisations, are barriers to successful integration of HTM into broader health systems.

It has long been recognised—in theory but much less so in practice—that creating an "enabling environment" is necessary for interventions to prevent and treat HTM to be most effective. For people who use drugs, in an environment of criminalisation, political hostility and stigmatisation, integration that simply involves the transfer of services from community-led initiatives to mainstream health services will be a regression. It will exclude peers; expose people who use drugs to more stigma, discrimination and harm; and mean less access, and access for fewer people, to health services. It will worsen inequalities and will be bad for individuals and public health. Governments, donors and UN agencies that advance integration without addressing such barriers are wasting funds, and if integration comes at the expense of community-led efforts, they are creating the conditions for worse health outcomes and greater down-stream costs to the health system. This undermines sustainable responses to HIV, TB, malaria and other health concerns, which is the opposite of the goals of integration.

Calls to Action

...to national and sub-national governments

- Explicitly integrate attention to the health and human rights of people who use drugs—including ensuring access to harm reduction and other health services—into **relevant policies** at national and/or provincial/state or local level, as relevant. This includes such things as National Strategic Plans on HIV and on TB, drug strategies, human rights plans, health sector strategies, etc. Of equal importance, integrate such commitments into **budgets** with ambitious but realistic budget allocations.

- Commit to the **meaningful involvement of people who use drugs** (and representatives of other key populations) in all bodies and processes responsible for making decisions shaping harm reduction and other health services we need, and decisions regarding the integration of HTM into broader health systems, including at the level of service delivery. If applicable, this also includes representation of people who use drugs on the Country Coordinating Mechanism (CCM), which is responsible for the country-level decision-making and oversight regarding a country's Global Fund grant.[15]

- "Integration" must include providing a **package of essential services**, defined and delivered in collaboration with community-led organisations and including harm reduction services and evidence-based treatment for drug dependence (including essential medicines, e.g., methadone, buprenorphine, and naloxone). These must be free of charge, and must **reflect the diversity of people who use drugs** and of the services needed to address different communities' needs and preferences. Countries should commit to a **time-bound plan for implementing the interventions recommended by the World Health Organization (WHO)** for addressing HIV, viral hepatitis and sexually transmitted infections (STIs) among people who use drugs.[16]

> Without guardrails, integration risks transferring clients from safe, community-led spaces into hostile PHC settings that can expose them to discrimination, embarrassment, violence, or even arrest... Communities articulate a nuanced perspective: they want integration to succeed, but not at the cost of safety, confidentiality, or dignity. Integration must not collapse community-led infrastructures that have taken decades to build, nor should it force [key populations] into PHC facilities that lack readiness.[17]

- **"Integration" can and should work both ways;** it does not necessarily or automatically mean transferring services from community-led spaces and models into mainstream, primary health care. Particularly in the case of criminalised or otherwise stigmatised populations such as people who use drugs, "integration" should **prioritise strengthening existing community-led systems to deliver enhanced services**, bringing health and other social services to people through these 'low-threshold' sites of engagement, where there is less risk and more trust.[18]

In keeping with the basic approach to integration stated above, community-led organisations should be supported to advance integration—where and how this is necessary and reasonable. The demand for integration should not be used an excuse to compel community-led organisations to deliver additional services—including as a condition of funding—when they are not well-positioned to do so or without adequate funding. Nor should it be used to compel them to deliver services in ways that would undermine the connection and trust with the populations they are already designed for and reaching. Such approaches to integration would weaken existing community-led systems. In turn, this would undermine, rather than improve, people-centered approaches, health outcomes and the long-term sustainability of the response.

> *" In some settings, some HIV or TB specialised services will need to be maintained in order to ensure quality and access, e.g., in harm reduction services."*
>
> Global Fund, Integration Technical Brief (December 2025)

Integrate **peer workers and staff of peer-led health and social services** into the response and sustain that engagement, including with fair compensation. Revise and harmonise national strategies on health human resource strategies accordingly.

> Despite the demonstrated value and importance of community-led responses, one widely shared view at INPUD's community consultation on integration was that absent significant changes by and to national health systems, integration of services for people who use drugs into those systems was virtually certain to sever the involvement of peers in important ways.[19]

- Develop **"integration readiness" standards** for certifying heath care facilities and staff as competent to provide care to key populations, including people who use drugs, *before* any services are transferred.[1] Community-led organisations must be involved in designing, monitoring and validating these standards. Minimum standards of "integration readiness" must include:
  - demonstrating the ability to provide services free of stigma and discrimination, and otherwise meeting quality guidelines such as those from the WHO;[20]
  - having mechanisms and policies in place to protect informed consent and patient privacy (including in their physical set-up of the facility, the handling of personal information, and safeguards against facility collaboration with law enforcement);
  - clear safeguarding and reporting mechanisms to protect against abuse and stigma (including gender-based abuses);
  - demonstrating effective and ongoing

1 UNAIDS has provided practical guidance, including checklists, outlining why and how to ground HIV prevention, testing, and treatment services in human rights standards, including ensuring equitable access for key populations such as people who use drugs: UNAIDS, Fast-Track and human rights: Advancing human rights in efforts to accelerate the response to HIV (2017). Although the guidance focusses on HIV services, the human rights standards outlined are applicable to health services more broadly. This guidance could serve as a resource for defining and assessing "integration readiness" of services. Some approaches to integrating HTM services into broader health systems come at the likely expense of community-organised spaces and services; this leaves key populations such as people who use drugs at heightened risk of harm when accessing generic, mainstream health services that have too often breached their rights. The push for integration heightens the importance of ensuring those services reflect human rights standards.

partnerships with organisations and networks led by key populations, and support for their work in the integrated delivery of services; and
- an enforceable commitment to participating in community-led monitoring (CLM) of services and to implementing ongoing improvements in service delivery and quality identified through such monitoring (and other mechanisms).

> "Successful integration hinges on communities having authority to shape service packages, define readiness criteria, evaluate [primary health care] facilities, and hold implementers accountable for safety and quality."[21]

- Invest **resources to build the capacity of facilities and staff** to become "integration ready." This includes ongoing training of those working in health services and adoption of necessary policies and operating procedures (e.g., for protecting human rights, evaluating performance, engaging in broader partnerships and referral networks, jointly defining roles of civil society and community-led organisations in the integration of services, etc.)

- As necessary, **adopt legal and policy changes to create a more "enabling environment"** for the delivery of harm reduction, rights-based drug dependence treatment and other health services, and to set standards of care that must be met.[22] This includes:

  - decriminalising drugs, people who use them, and the health services we need, and redirecting the funds freed up from policing, prosecuting and imprisoning people to evidence-based health services that respect and protect human rights;
  - removing unwarranted restrictions that limit who can deliver certain services and where, how and to whom; and
  - ensuring adequate protection of service users' rights to freedom from discrimination, informed consent to interventions, and confidentiality.

> *"Integrated care can be great. It can also be real persecution, where you don't get proper health care. Integration in a well thought-through policy system, with the right practitioners, who are trained and supported, is very different from integration in a hostile policy environment and dealing with inexperienced, unthoughtful practitioners. This underscores the huge benefit of community-led organisations being mediators for people with such systems. Integration can be great, but it's often not about being great, it's often about doing things more cheaply and pushing people back into lower-quality care where stigma and discrimination are maximised."*
>
> Participant, INPUD community consultation 19 January 2026

- Support **community-led data collection, including community-led monitoring of services**. Include adequate funding for such work in funding requests (e.g., to the Global Fund, bilateral donors) and in domestic budgeting.

… to service providers

- **Advocate for government action** on the points above, including:

  - incorporating health services for people who use drugs, including harm reduction, into relevant policies and budgets;
  - meaningfully involving people who use drugs in decision-making bodies and processes; and
  - defining a minimum package of harm reduction services and working towards a comprehensive set of WHO-recommended interventions.

- **Become "integration ready."** Adopt institutional policies and operating procedures, and train employees and volunteers, so that your facility and staff meet standards of ethical, quality care. (Minimum standards which INPUD advocates are described above.[23]) This should be done *before* harm reduction or other services for people who use drugs are integrated with your service.

- **Engage with civil society and community-led organisations,** including those led by people who use drugs, to discuss *how* services should be integrated so as to maximise benefits for the intended service users. As noted above, successful integration goes both ways: especially for stigmatised and criminalised populations, the best approach to integration is to integrate primary health care services into community-led models for delivering services.

- Integrate **peer workers and staff of peer-led health and social services** into the response and sustain that engagement, including with fair compensation.

...to donor governments and funders

- **Increase funding** for global health, including support for addressing HIV among people who use drugs.

- **Dedicate multi-year funding** for: harm reduction services; community-led organisations of people who use drugs (and other key populations); and advocacy for harm reduction, domestic financing for it, as well as for legal and policy changes needed to remove barriers to HIV prevention and treatment for people who use drugs and to protect our human rights.

- Commit funding that supports the **core costs of civil society organisations**, including organisations by and for people who use drugs.

- **Track funding over time**, to monitor progress in meeting agreed-upon targets for strengthening communities' response to HIV.

...to the Global Fund

- Require **representation of people who use drugs** on the Country Coordinating Mechanism (CCM) as a non-negotiable grant condition.[24]

- Make it a condition of all grants that communities, including representatives of key populations, are **equal, co-governing partners** in all bodies and processes responsible for making decisions regarding the integration of services, whether at the national or sub-national level. This includes the development of "integration readiness" standards and plans and the assessment of integration readiness.

- Require countries receiving grants to make a realistic commitment to **co-finance evidence-based services**

needed for the health of people who use drugs, as recommended by the WHO, with clear mechanisms for tracking follow-through on this commitment.[25]

- Dedicate funding to support community-led responses, both through a **direct funding stream** and by **earmarking a specified amount of funding in country allocations** for community-led organisations. This should include funding for community-led organisations to *provide services* but also to *undertake complementary activities essential to reducing barriers to health services*, such as: eliminating stigma and discrimination in all settings (including health care); improving the legal and policy environment to enable a more effective response; improving legal empowerment and access to justice; transforming harmful gender norms; addressing gender-based violence; and conducting broader advocacy efforts. As Global Fund guidance recognises: "Tackling human rights and gender-related barriers that prevent people from accessing health services remains critical to delivering effective interventions. Even the most powerful biomedical innovations are of little use if those who need them the most cannot access them."[26] Direct funding from the Global Fund for community-led organisations and community-based organisations serving key populations should also include some form of **"rapid response" fund** to support organisations facing an acute crisis situation and/or potential disruption to essential, lifesaving services.

- During grant-making, review the **grant implementation arrangements** to preserve meaningful support for community systems, leadership and responses, and to ensure that tenders and other requirements do not exclude drug user-led organisations and networks, or other community-led organisations. Particularly in settings where the government criminalises or vilifies people who use drugs and the health services we need, or maintains legal and policy hurdles to the effective operation of drug user-led organisations, **avoid having a single government entity as the Principal Recipient** of a grant. Where necessary, the Global Fund should require countries to adopt time-bound plans for **enabling 'social contracting'** so that community-based organisations, including community-*led* organisations, can be contracted to provide services, particularly for key populations.

- Proactively **coordinate technical assistance** from different initiatives, including those funded by donors to the Global Fund, to ensure benefits to organisations and networks led by key populations, including people who use drugs.

- Ensure that grants' Performance Framework includes **monitoring and evaluating** the extent to which the process of integration is (i) informed by the meaningful involvement of key populations; (ii) affecting funding for, and delivery of, services by community-led organisations; and (iii) affecting uptake of services, including by key populations.

- **Follow the money:** Monitor and report on the extent to which Global Fund and other external grants are funding community-led organisations, including those of people who use drugs, in order to assess progress in closing service and programming gaps for people who use drugs while meeting agreed-upon targets for strengthening communities' response to HIV.[27]

- **Sustain services and communities:** Even when a country transitions out of being generally eligible for funding from the Global Fund, allow community-led organisations within that country to be eligible for grants for harm reduction services and for advocacy for harm reduction, for legal and policy reform, and for defending and promoting the human rights of people who use drugs, if they can demonstrate there is no realistic possibility of domestic funding for these activities. This would be a clear indicator that a country is failing in its approach to "integration." The push for faster integration cannot come at the expense of the Global Fund's commitment that it "puts people and communities at the centre of all our work."[28]

….to Country Coordinating Mechanisms and Principal Recipients (in countries receiving Global Fund grants)

- **Ensure people who use drugs and our organisations** are meaningfully and respectfully involved in all bodies and processes responsible for making decisions regarding Global Fund grants that implicate harm reduction and other services we need, including the implementation of integration of such services with broader health systems.

- In the case of **CCMs**, in keeping with the letter and the spirit of Global Fund policies:

  - They must establish a **mechanism to engage key populations**, people living with or affected by the three diseases, and civil society, throughout the grant lifecycle, "in a way that allows their input and voices to be heard."[29]

  - They must always include a representative **of people who use drugs**. Despite claims to the contrary—often based on an inability or unwillingness, because of stigma and criminalisation, to gather population data systematically—we are everywhere and we are at risk. Criminalisation of (people who use) drugs, and in some settings, legal restrictions on the existence of our organisations, are not an acceptable rationale for denying us equal, effective representation on CCMs (or other similar coordinating/decision-making bodies).[30]

  - CCMs must **operate in keeping with principles of good governance**, including: transparency of information, which requires the timely, equal and comprehensive sharing of information; equality among members; accountability; and conflict of interest management.[31] Timelines should allow for proper community consultations.

  - At least 15% of the CCM's **funding must be allocated to activities to support the engagement of civil society and communities**, including key populations, in CCM consultations and to improve the quality of their participation.[32]

- With respect to **Principal Recipients** (PRs),
  - Selection of a Principal Recipient must include consideration of its **ability, willingness and commitment to partner** with community-led organisations from key populations, including people who use drugs.
  - The Principal Recipient's **tendering processes and requirements for selecting sub-recipients** should not exclude qualified community-led organisations of people who use drugs from being contracted to implement activities supported by a Global Fund grant.
  - A Principal Recipient should **support community-led responses** by:
    - ensuring key populations are meaningfully engaged not just at the outset, during the development of a funding request, but throughout the entire grant lifecycle;
    - ensuring adequate funding within the grants managed by PRs to support community representatives on the CCM to be able to meaningfully contribute to CCM activities, including through technical assistance to build capacity and ensure effective feedback loops with communities;
    - providing technical support to strengthen the capacity and leadership of community-led organisations to implement Global Fund-supported activities; and
    - tracking the percentage of funding allocated to key population-led organisations, with a view to achieving the internationally agreed targets for strengthening communities' response to HIV.[33]

….to UN agencies with relevant mandates

- Contribute to the development and updating of **global technical guidance on integration** and support countries with **technical assistance** for successfully implementing the integration of HTM with their broader health systems. Such guidance and assistance should:
  - specifically address how to integrate harm reduction and other health services for people who use drugs in ways that benefit us and do not expose us to further stigma, discrimination, criminalisation or other breaches of human rights, and in ways that preserve our leadership role in ending the three diseases, through meaningful engagement at all levels of decision-making and through community-led and community-based delivery of services;
  - be rooted in human rights principles and standards[34] —including our meaningful involvement as people who use drugs—and in the evolving body of evidence as to approaches that work and those that do not; and
  - be consistent across agencies in supporting harm reduction and decriminalisation of drugs and people who use drugs, in line with the UN system common position.[35]

> *" Integration, when communities lead it, means expanding the scope of what community-led organisations deliver while ensuring they have the resources, formal recognition and enabling legal environments to operate sustainably as permanent partners within national health systems.*

> *" The question is not whether the government or community should lead HIV services. The question is how to structure, resource and protect a complementary ecosystem in which both can thrive, with community-led organisations recognised and funded as essential, specialised service providers with distinct roles than government systems cannot fulfill."*[36]
>
> NGO Report, UNAIDS Programme Coordinating Board (December 2025)

Endnotes

1. See the overview and description of different components of health systems in: *Global Fund, Accelerating Integration of HIV, TB and Malaria to Strengthen Health Outcomes: Technical Brief (Grant Cycle 8)*, 15 December 2025 ["Integration Technical Brief"].
2. Integration Technical Brief. See also: SM Topp et al., "Advancing functional and systemic integration of HIV prevention into public health systems," *Lancet Glob Health 2026*; 14: e121–30, https://doi.org/10.1016/S2214-109X(25)00397-3; S Sweeney et al, "Costs and efficiency of integrating HIV/AIDS services with other health services: a systematic review of evidence and experience," Sex Transm Infect 2012;88: 85e99, https://doi:10.1136/sextrans-2011-050199.
3. Sustainable Development Goals, Target 3.8, https://sdgs.un.org/goals/goal3#targets_and_indicators.
4. Sustainable Development Goals, Target 3.3, https://sdgs.un.org/goals/goal3#targets_and_indicators.
5. UNAIDS, *United Towards Ending AIDS: The Global AIDS Strategy for 2026-2031*, adopted by the UNAIDS Programme Coordinating Board, December 2025, UNAIDS/PCB (57)/25.30.
6. Ibid.
7. Global Fund, *Advancing Integration, supra.*.
8. Harm Reduction International, *The Global State of Harm Reduction 2024* (2024); Harm Reduction International, *The Cost of Complacency: A Harm Reduction Funding Crisis* (2024).
9. Ibid.
10. Harm Reduction International, *The Global State of Harm Reduction: 2025 Update to Key Data* (2025).
11. International Network of People who Use Drugs, *The Human Cost of Policy Shifts: The Fallout of United States' Foreign Aid Cuts on Harm Reduction Programming and People who Use Drugs: Rapid Assessment Findings—April 2025* (2025). See also: Harm Reduction International, *The impact of US funding cuts on harm reduction* (2025).
12. Ibid.
13. As set out in the *Global AIDS Strategy 2021-2026*, community-led organisations should be delivering 30% of testing and treatment services; 80% of HIV prevention services; and 60% of programmes addressing societal enablers. Those targets have been preserved in the new *Global ADS Strategy 2026-2031*.
14. INPUD, *The Human Cost of Policy Shifts, supra,* p. 21.
15. For more detailed discussion, see: INPUD, *Country Coordinating (CCM) Engagement and why it is important for People who Use Drugs* (2023).
16. World Health Organisation et al. *Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs: Policy brief* (2023).
17. Guardrails for Integration, supra.
18. For more in-depth discussion, see *NGO Report: Community-led integrated HIV services: The future of a sustainable HIV response*, UNAIDS Programme Coordinating Board, UNAIDS/PCB(57)/25.28.rev1 (December 2025), and for some examples of integration of harm reduction services with other services, see Harm Reduction International, *Integrated and Person-Centred Harm Reduction Services* (2021).
19. Numerous participants, INPUD community consultation on integration, 19 January 2026.
20. WHO, *supra*.
21. Guardrails for Integration: KVP Community Leadership in Shaping HIV-Primary Health Care Integration – Study Conducted Across East, West and Southern Africa 2023-2025 (COMPASS & Key Populations Trans-National Collaboration, 1 December 2025).
22. The International Guidelines on Human Rights and Drug Policy (https://www.humanrights-drugpolicy.org/) provide guidance about what a human right-based to laws and policies related to drugs can and should entail, creating that more enabling environment. The Guidelines, first launched in 2019, were developed and endorsed by the International Centre on Human Rights and Drug Policy, UNDP, UNAIDS, WHO and OHCHR.
23. And see also resources such as the UNAIDS guidance on *Fast-Track and human rights: Advancing human rights in efforts to accelerate the response to HIV* (2017).
24. For more detailed discussion, see: INPUD, *Country Coordinating (CCM) Engagement and why it is important for People who Use Drugs* (2023).
25. World Health Organisation et al. *Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs: Policy brief* (2023).
26. The Global Fund requires that every grant include evidence-based investments in interventions that address identified human rights- and gender-related barriers to life-saving services for those most at risk: Global Fund, *Grant Cycle 8 | Enabling Impact: Tackling Human Rights & Gender Barriers to Accessing Services*, 17 April 2026..
27. See the targets set out in the *Global ADS Strategy 2026-2031*.
28. Global Fund, *Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy (2023-2028)*.
29. Global Fund, *Country Coordinating Mechanism Policy Including Principles and Requirements* (10 May 2018), para 15.
30. For more detailed discussion, see: INPUD, *Country Coordinating (CCM) Engagement and why it is important for People who Use Drugs* (2023).
31. Global Fund, *Country Coordinating Mechanism Policy Including Principles and Requirements, supra,* para 19.
32. Global Fund, *Operational Policy Manual* (2025), see Operational Policy Note: Country Coordinating Mechanism Funding, para 18.
33. See the targets set out in the *Global ADS Strategy 2026-2031*.
34. E.g. the *International Guidelines on Human Rights and Drug Policy*, developed and endorsed by the International Centre on Human Rights and Drug Policy, UNDP, UNAIDS, WHO and OHCHR, online at https://www.humanrights-drugpolicy.org/.
35. UN Chief Executive Board for Coordination, *"United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration,"* UN Doc. CEB/2018/2, Annex I (18 January 2018).
36. NGO *Report, supra*, paras. 29-30.

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 will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs, and their impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national and regional levels.

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