Pandemic Preparedness and Response

Voices of People who Use Drugs

International Network *of* People *who* Use Drugs

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1. Introduction

The COVID-19 pandemic has illuminated myriad weaknesses in the global health system's ability to prepare for, respond to, and mitigate a global pandemic. The social, economic, and health impacts resulting from this lack of preparedness have been devastating for everyone, but perhaps for none more so than groups who were already marginalised, criminalised, and stigmatised, such as people who use drugs.

The disproportionate impacts are beginning to be documented by researchers. In New York City, people who inject drugs reported "higher levels of mental health issues, syringe reuse, and alcohol consumption and greater reductions in syringe-service programs and buprenorphine utilization" than prior to the pandemic (Aponte-Melendez et al., 2021). In Scotland, the number of HIV tests and HCV tests available in drug services and closed settings, and the number of needles and syringes distributed "decreased by 94%, 95%, and 18%, respectively, immediately after lockdown" (Trayner et al., 2022).

Public health measures intended to prevent the spread of COVID-19 created impacts and harms to people who use drugs. Lockdowns negatively impacted their mental health and ability to earn a living (Kesten et al., 2021). Social distancing guidelines forced people who use drugs to "choose between avoidance of COVID-19 and the intimacies of drug use that contribute to their survival" (Schlosser and Harris, 2020). The pandemic affected this community simultaneously with multiple other pandemics — including HIV, hepatitis C, and tuberculosis — but with health services disrupted, many were unable to access needed treatment.

The current moment demands an accounting of these and other impacts and harms, as well as the proposal to develop new international binding law in order to fix the many things broken in global health. It also offers an opportunity to take action, ensuring that harms are not repeated in future public health emergencies.

The World Health Organization (WHO) is supporting a country-led process to develop a WHO convention, agreement, or other international instrument on pandemic prevention, preparedness, and response (currently referred to by WHO as 'the WHO CA+', but referred to here as the 'Pandemic Treaty'). At the same time, many countries are also conducting national pandemic preparedness and response assessments to inform future planning and priority-setting. These processes have been critiqued for replicating existing inequalities, and as such greater participation is needed.

During the COVID-19 pandemic, the International Network of People who Use Drugs (INPUD) conducted two independent surveys to gain insight into the experiences of people who use drugs during the COVID-19 pandemic. INPUD found that in addition to widespread loss of life, many respondents who use drugs experienced related health impacts

due to difficulty accessing health and harm reduction services (including opioid agonist therapy (OAT), access to overdose treatment, and more). Many said they were particularly affected by the ongoing negative impact of criminalisation, stigma, and discrimination, as well as the sharp increase in gender-based violence (GBV) during travel and movement restrictions. At the same time, they reported innovation and community mobilisation (INPUD, 2020a and b). These two INPUD surveys, conducted in six languages, garnered important insights.

INPUD also has extensive experience with participating in global health and human rights mechanisms that, combined with this knowledge and expertise, positions the network well to contribute to the process of developing new international norms. INPUD also brings an unwavering commitment to harm reduction, human rights, and the meaningful participation of the drug-using community in the development, implementation, and monitoring of policies, programmes, services, and initiatives that impact drug users' lives. This positions the network well to contribute to redefining what pandemic preparedness and response means for people who use drugs and the global community.

This qualitative research study was led by INPUD, in collaboration with social science researchers at the Global Health Centre of the Geneva Graduate Institute to learn more about the continuing impacts of COVID-19 on the community and to develop shared positions in relation to the pandemic treaty. It used a community-engaged approach to:

- Inform INPUD members of current developments and processes in global health governance in response to COVID-19, including the securitisation of global health, the proposed pandemic treaty, and related debates;
- Further investigate the diverse experiences of people who use drugs in the COVID-19 pandemic with harm reduction policy, drug use and supply, policing, detention, and human rights; and
- Develop a set of policy recommendations based on evidence from the research that can be utilised during INPUD's future advocacy.

The report presents background to the development of the pandemic treaty, methods, and findings from the research, and analysis and policy recommendations.

2. Background

In 2021, the International Pandemic Preparedness and Response Panel (IPPPR) report, COVID-19: Make it the last pandemic, found that countries had been slow to respond to COVID-19, and that international financing had been "too little, too late". Early disease detection systems were underused; some governments attempted to downplay the severity of disease incidence; other countries were reluctant to share information and samples; and there were global shortages of PPE, as well as, of course, vaccines – thanks to what some called "vaccine nationalism" or "vaccine apartheid" (Kupferschmidt, 2020).

The WHO and some member states recognised these weaknesses and the need to address them. Proponents believe a pandemic treaty would aid global improvement of preparedness and response efforts. Critics call this an effort to distract from the need to make deeper changes to the global economic and global health governance systems that reinforce inequalities. Nonetheless, progress on the pandemic treaty is underway, and this may lead to new binding international law which would for the first time include mechanisms for monitoring and evaluation of compliance by countries (Nikogosian and Kickbusch, 2021).

To frame the study and inform future advocacy, this background section provides an overview of global pandemic preparedness and response, then discusses the International Health Regulations (2005) (IHR) and its evaluation tools, and summarises the current critiques of the potential treaty.

A. PANDEMIC PREPAREDNESS & RESPONSE

It may be helpful to begin by defining terminology. 'Pandemic preparedness' usually refers to health systems strengthening and capacity-building activities to ensure health systems can withstand additional stress brought on by pandemics. Specific pandemic preparedness activities include, for example, creating multi-stakeholder preparedness plans for disasters and emergencies; ensuring access to countermeasures (such as PPE, therapeutics, diagnostics, and vaccines); strengthening procurement, logistics, and supply chains; training and expanding the healthcare workforce; expanding health management information systems; and more. The Global Fund also emphasises that community systems strengthening is an integral part of pandemic preparedness (The Global Fund, 2022). Pandemic preparedness aims to ensure that countries have the resources, funds, and capacity to adequately respond to the added stress of pandemics.

'Pandemic response' refers to a country's ability to successfully respond in real-time to the onslaught of challenges brought on by a pandemic. It includes activities such as generating successful communication plans, which properly educate the public and address disease misinformation and disinformation, utilising strategies to reach key and vulnerable

populations who often lie at the crux of multiple pandemics, and deploying emergency funds to programmes and populations that require extra support (The Global Fund, 2022). In terms of disease monitoring, pandemic response increasingly involves the use of digital surveillance systems to monitor outbreaks. Pandemic response measures are critical to not only curbing the further spread of disease, but also to mitigating the hardships they create.

B. INTERNATIONAL HEALTH REGULATIONS AND RELATED ASSESSMENTS

The International Health Regulations (2005) (IHR) are a binding instrument of international health law ratified by 196 countries. However, the COVID-19 pandemic showcased the weaknesses of the IHR.

In ratifying the IHR, countries commit to ensuring their national surveillance and health systems have capacity to detect and respond to outbreaks, report any outbreaks rapidly to the WHO, respond to the WHO's requests for information, and refrain from imposing unnecessary restrictions to international traffic and trade. However, as some critics have noted, most countries failed to comply during COVID-19. Sohn and colleagues (2021) point out,

> Among the IHR problems that have been continuously raised, COVID-19 highlighted: 1) the provision of notifications and information based on the evaluation of potential public health emergencies of international concern (PHEICs), 2) the timing of WHO's PHEIC decisions and declaration, procedures and warning systems, 3) measures to respond to infectious diseases against IHR, 4) WHO's lack of funds (Sohn et. al., 2021: 1).

While some feel that WHO was slow to act, in other words, countries were even slower to respond to WHO's declaration of a "public health emergency of international concern", the declaration that triggers the IHR. This is in part because the IHR lacks any independent oversight or enforcement mechanism. Instead, countries assess themselves for compliance using two tools – the *States Parties Self-Assessment Annual Reporting Tool (SPAR)* and the *Joint External Evaluation (JEE).*

These tools largely failed to predict how ready (or not) countries were for the COVID-19 pandemic. The SPAR is an annual, country-led, multi-sectoral self-assessment process in which countries that ratify the IHR are required to report progress towards IHR core capacity implementation. This includes assessing 13 separate areas, broken down into a number of indicators, and graded on five levels of performance. The JEE is a voluntary, external, peer-reviewed evaluation which complements the SPAR, and should occur once every 4–5 years at request by the member state (Razavi et al., 2021). In addition to these tools, other external tools have been developed to assess country readiness to cope with a public health emergency, such as the Global Health Security (GHS) Index.

All these tools were widely applied before the COVID-19 pandemic. However, in its first report assessing the response to COVID-19, the above-mentioned IPPPR found the tools

had failed to adequately predict COVID-19 death rates. The tools also missed the weaknesses of health systems in some high-income countries; and failed to predict the lack of political will to respond effectively to outbreaks by populist leaders in the US, UK, and Brazil, among others (Batreau and Townsend, 2022; COVID-19 National Preparedness Collaborators, 2022).

Some experts have found that the largest predictors of success during a pandemic are public trust in governments and interpersonal trust; this may be unsurprising to many in civil society and affected communities. Interpersonal trust is intrinsic to communities, and is key to the work done by peer-led networks during a crisis, such as networks of people who use drugs. Unfortunately, these are characteristics the SPAR, JEE, and other tools did not assess.

In sum, countries reported themselves as doing very well in preparing for a public health emergency of international concern, and there was no mechanism in place to challenge that optimistic self-assessment.

Had civil society and communities been included in the assessment process, they might have warned that governments had created overly optimistic self-assessments. However, they were not included.

C. PROPOSALS FOR A PANDEMIC TREATY AND (LACK OF) ROLE FOR CIVIL SOCIETY

As the COVID-19 pandemic made clear that the IHR and its related assessment tools were not fit for purpose, countries have launched efforts through WHO's platforms to revise the IHR, and some have called for a new pandemic treaty that could fill the gaps in global health governance, strengthen cooperation among countries, and lead to new financial resources for pandemic prevention, preparedness, and response.

Thus, in November 2021, member states in the World Health Assembly, one of the governing bodies for WHO, established an International Negotiating Body (INB) to draft and negotiate a new treaty and a Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR) (WHO, n.d.).

The INB process is led by member states and, once again, there is no formal mechanism for civil society participation. Thanks to pressure by civil society, in April 2022 the INB did hold public hearings, but oral interventions were limited to 2-minute statements, and written submissions were limited to 250 words (Hodgson and Davis, 2022). Civil society groups 'in official relations' with WHO may observe INB meetings, and sometimes make comments, but these opportunities are limited. A Civil Society Alliance for Human Rights in the Pandemic Treaty (CSA), of which INPUD is a member, is advocating for more meaningful participation by civil society and communities in the process. One proposal has been to establish an External Conference of Parties (E-COP) for governance of the pandemic treaty, which could include civil society along with other stakeholders. While some civil

society groups have endorsed this idea, others have raised concerns that this would open up space for influence by large corporations and private foundations, such as the Bill and Melinda Gates Foundation (KEI, 2022). A broader discussion may still be needed to determine what role, if any, civil society will play in the future E-COP.

In December, the INB met to discuss a *Conceptual Zero Draft* of the treaty, which set out proposed concepts that could be included in a future zero draft. The concepts included equity, technology transfer, intellectual property, regulatory reforms, proposals for future Research and Development (R&D), information-sharing, One Health (addressing the relationship between humans, animals, and the environment), financing, and governance. The Conceptual Zero Draft addresses equity between countries, and also calls for engagement among states and "civil society, communities and non-State actors, including the private sector" (WHO 2022, p. 23). While it emphasises the need for financing, it does not address the need for financing of community-led responses. Some civil society comments on the draft noted the lack of clear reference to government obligations under human rights law (Privacy International, 2022).

INPUD (2022b) shared a statement on the Conceptual Zero Draft and circulated it to member states taking part in the INB process, as well as the WHO Governance Unit. The statement called for support for community-led and peer-based responses; for innovations in care, such as OAT flexibilities; for resources to prevent and respond to gender-based violence affecting women who use drugs; and for meaningful involvement of communities in all aspects of pandemic prevention, preparedness and response (INPUD, 2022d).

The conceptual zero draft will now inform a zero draft of the treaty, which will be shared at the beginning of February 2023 for discussion by the WHO Executive Board. Drafting groups will begin to negotiate the language. An update on the process is planned for the World Health Assembly in May 2023.

D. HUMAN RIGHTS, GENDER EQUALITY AND DECOLONIALITY

While a pandemic treaty could bring many benefits to global health coordination, critics have raised concerns about the need to address larger underlying inequalities, including gender inequalities and the lasting impacts of colonialism, while strengthening human rights protections. Before turning to INPUD's research findings, it is important to introduce these critiques.

Global health security is defined by the WHO as "the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries" (WHO, n.d.). In practice, global health security discussions have largely concentrated on curbing emerging infectious diseases like HIV, Zika, SARS, and Ebola in the 'Global South' that might spread to the 'Global North', rather than addressing the priority health concerns of low- and middle-income countries.

For some, this begs the question – *whose* security is being promoted in global health security? Hassan argues, “Global health security is not global in essence, and serves to protect the interests and security of those in positions of power” (Hassan, 2022). A global movement to decolonise global health has emphasised the need to shift decision-making, power, and funding away from donor-driven agendas, and toward low- and middle-income countries. Some argue that the pandemic treaty process distracts from the need to address harms caused by capitalism and global economic inequality, and suggests that future global health multi-stakeholder mechanisms could enable the continued domination of large corporations and other private interests, reinforcing those inequalities instead of remedying them (Dentico et al., 2021). Others have argued that a focus on global health security is distracting from the need to strengthen health systems, and address the underlying determinants of health, such as housing, water and education. Civil society organisations have raised concerns about the sidelining of human rights in the pandemic treaty process (The Civil Society Alliance for Human Rights in the Pandemic Treaty, 2022; Davis et. al., 2021).

Feminist scholars also argue that “because global health security lacks a substantive feminist engagement, policies created to manage an outbreak of disease focus on protecting economies and state security and disproportionately fail to protect women” (Wenham, 2021). This critique calls for more attention to “visibility, social and stratified reproduction, intersectionality, and structural violence” (ibid).

All these critiques help to create a larger discussion in which INPUD has unique contributions to make, based on its own expertise and experience. By focusing on the needs of those who are marginalised, INPUD can champion a process that works for all. INPUD can also help to ensure that positive innovations which emerged during the COVID-19 pandemic for people who use drugs, like increasing access to OST and other harm reduction services and flexibilities (Kesten et al., 2021; Aponte-Melendez et al., 2021), and the recognition of the importance of mutual aid within communities (Boucher et al., 2022), is sustained and enforced in international law. INPUD can also promote the meaningful inclusion of people who use drugs in global health governance, beyond the HIV sector and the need to finance community-led responses as a core part of strengthening health systems for pandemic preparedness and response.

3. Research Methods

The study built upon INPUD's earlier research during the COVID-19 pandemic, and aimed to go deeper in order to answer the following research questions:

1. What caused some of the harms and challenges faced by people who use drugs during the COVID-19 pandemic, what were some positive innovations (technological, policy, community-led and others) that ameliorated the impact of COVID-19, and what are the continuing impacts and outcomes of the pandemic and its response on this community?
2. How prepared were governments, international organisations, and civil society (including peer-led networks) to address the needs of criminalised and marginalised populations, including a) risks linked to expanded surveillance and policing during the pandemic, and b) the impact of multiple simultaneous pandemics (COVID-19, HIV, HCV, TB)?
3. What can we learn from the COVID-19 pandemic to enable better pandemic preparedness and response in the future?

To answer these questions, the study used a participatory action research approach, in which the population being studied participated in the design, data-gathering, and analysis, and reflected on the findings for action. To do this, INPUD staff participated in the study as a co-principal investigator and established a Community Research Board, who reviewed all research instruments, participated in the study, and reviewed final written products.[1]

The study used a three-pronged approach to data gathering:

1. **Desk review.** The research team conducted a desk review of academic and grey literature on the pandemic treaty and impacts of the COVID-19 pandemic on people who use drugs.
2. **Key informant interviews.** The research team conducted qualitative semi-structured interviews with eight leaders of national and/or regional networks of people who use drugs, which included individuals from seven out of eight of INPUD's geographic regions. Interviews were conducted between 3 October 2022 - 28 October 2022. Each interview lasted between 30 minutes to one hour and were conducted on Zoom. Interviews aimed to elicit experiences of the community represented during COVID-19, lasting impacts, and policy recommendations.
3. **Webinars and focus group discussions (FGDs).** The research team conducted three hour-long webinars to engage INPUD members as co-learners in the study process, followed in each instance by an hour-long online FGD with participants who identified as people who use drugs. A total of 35 respondents participated in the webinars and focus group discussions, including 18 participants in the first FGD, 10 participants in the second FGD, and seven participants in the third webinar.

1. Community Research Board Members: Anton Basenko, Ernesto Cortes, Yatie Jonet, Angela McBride, Danielle Russell.

a. The first webinar and FGD on 19 September 2022 was titled Pandemic Preparedness and Response for People Who Use Drugs. It featured presentations by an expert on national PPR assessments using SPAR, and a presentation of INPUD's 2020 survey results, along with Q&A. The hour-long FGD explored INPUD members' experience during the COVID-19 pandemic.
b. The second webinar and focus group discussion on 5 October 2022 was titled Do we need a Pandemic Treaty?. It featured presentations by a member of the CSA explaining why they see it as valuable to engage in the process, a critique of the process shared by a speaker from the Geneva Global Health Hub (G2H2), and reflections by INPUD. The webinar was followed by a facilitated one-hour FGD exploring questions and concerns about the treaty.
c. The third and final webinar and FGD was held on 5 December 2022. The research team presented the initial research findings and collective analysis. During the second half of the webinar, participants discussed the findings and draft policy recommendations. As the third webinar focused on discussion of the draft findings and recommendations and did not include interviews, no demographic data was gathered for this webinar.

Coding.
All interviews and FGDs were transcribed, and then coded and analysed using Dedoose, a cloud-based platform for qualitative analysis. Three co-PIs (principal investigators) and researchers from INPUD and the Geneva Graduate Institute developed a shared codebook based on the literature review and the previous INPUD studies, and deductively analysed themes and patterns in the transcripts, with each transcript reviewed by a second coder.

Ethics.
The main risks to participants included a) the risk of being identified outside the context of the FGD or KII as people who use drugs and/or as people living with stigmatised health conditions (such as HIV, HCV, TB); b) the risk of re-traumatisation while disclosing harm experienced during the COVID-19 pandemic, which could include experiences of abuse, loss, ill-health, or other traumatic experiences; c) the risk that a participant may say something critical about a powerful actor (a state agent, UN agency, donor agency, or powerful civil society organisation) which is shared outside the FGD or KII and leads to repercussions to the individual who expressed those views.

To address these risks, registration was handled by staff of INPUD. All participants provided written informed consent in the registration process. Respondents were encouraged to use pseudonyms, and to keep cameras off. Researchers used codes to refer to all FGD participants and KII respondents in all communications within the team.

Many participants opted to use their real names, as those participating in the study have experience in dealing with these and related risks in their ongoing national and global advocacy work. As Co-PI, INPUD staff also played a central role in considering potential risks and how to mitigate them in the process.

4. Findings

A. SAMPLE

A total of 43 participants engaged in the study, including eight individuals who participated in key informant interviews, and 35 individuals who participated in focus group discussions.

Overall, FGD participants were predominantly male (45%, n=35) with a significant number identified as female (34%, n=35) and two identified as non-binary; five declined to provide a gender identity. 37% of the FGD participants were between 36-45 years of age, while 31% were between 26-35 years. African network members were well-represented, with the smallest numbers from Latin America and the Caribbean, perhaps in part due to language and time zone issues. This balance was similar among key informant interviews (see Table 1 and Figures 1, 2, and 3.)

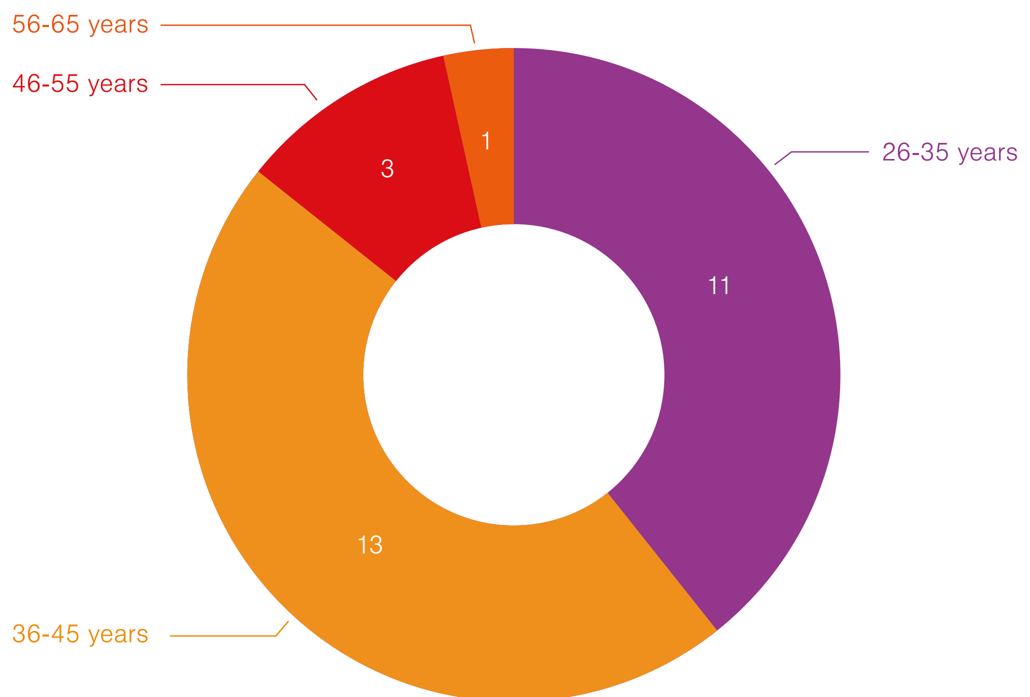

Figure 1. Age Range of FGD Participants*

* Seven out of 35 participants chose not to provide their age range.

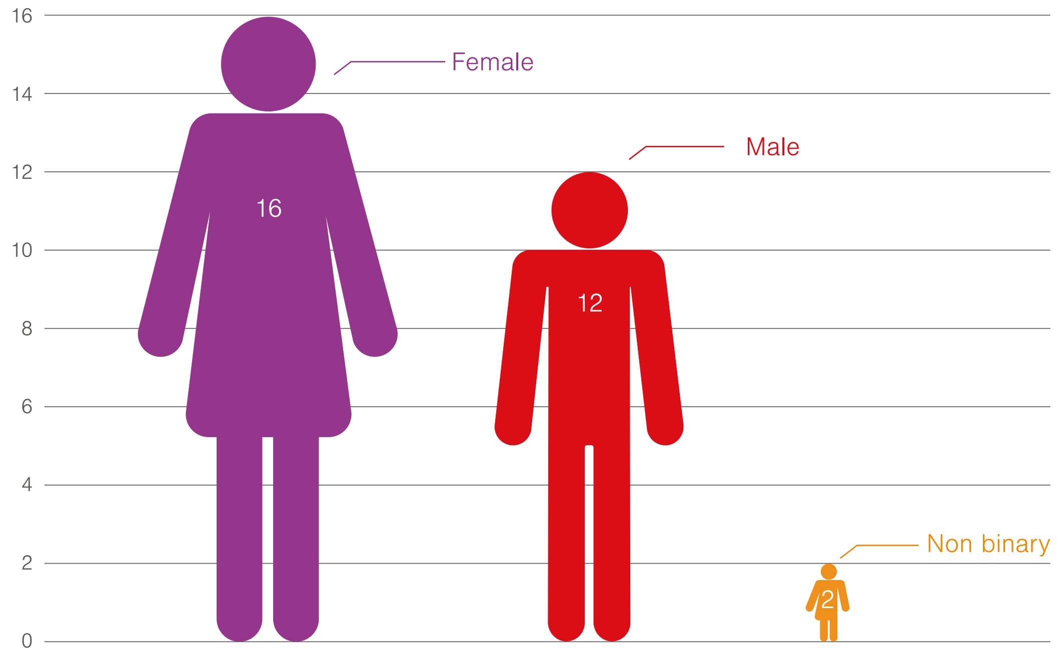

Figure 2. Gender Identities of FGD Participants*

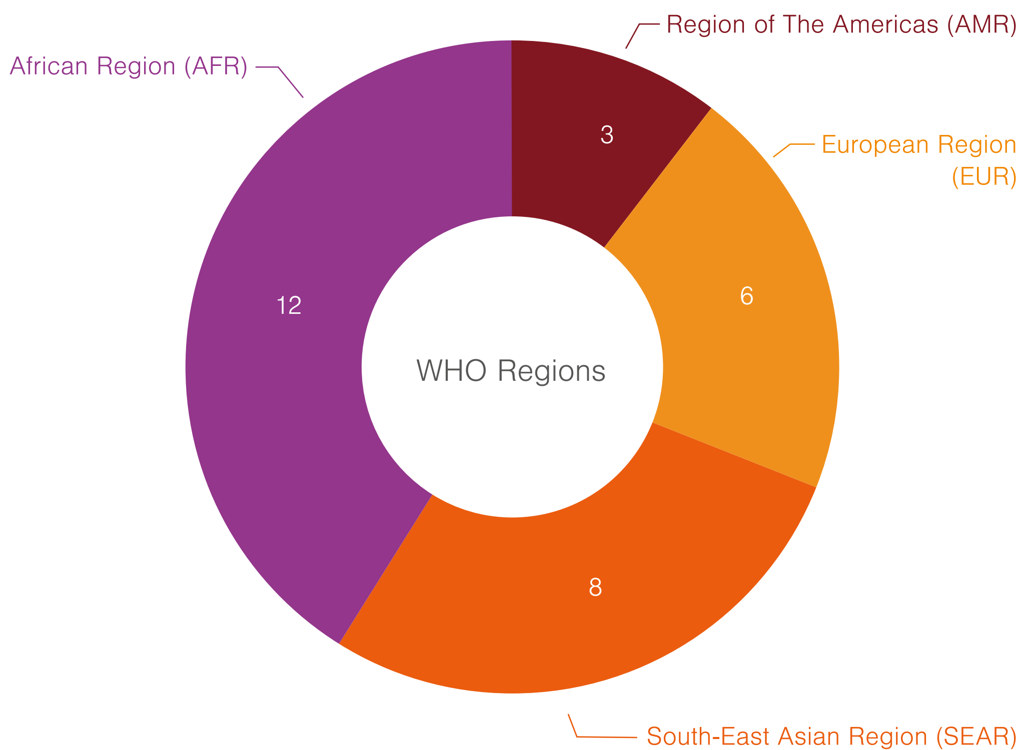

Figure 3. FGD Participant Geographic Regions **

* Five out of 35 participants did not provide their gender identities.

** Six out of 35 participants did not provide their geographic regions.

ID Number	Gender	Network	WHO Geographic Region
KII-1	Male	African Network of People who Use Drugs (AfricaNPUD)	African Region (AFR)
KII-2	Female	South African Network of People who Use Drugs (SANPUD)	African Region (AFR)
KII-3	Female	Harm Reduction Victoria	Western Pacific Region (WPR)
KII-4	Male	Latin American Network of People who Use Drugs (LANPUD)	Region of the Americas (AMR)
KII-5	Male	European Network of People who Use Drugs (EuroNPUD)	European Region (EUR)
KII-6	Female	Eurasian Network of People who Use Drugs (ENPUD)	European Region (EUR)
KII-7	Male	Indian Drug Users Forum	South-East Asian Region (SEAR)
KII-8	Male	Canadian Association of People who Use Drugs (CAPUD)	Region of the Americas (AMR)

Table 1. List of Key Informant Interviews

B. THEMES

Interviewees shared many similar concerns. These included:

- the economic impact of pandemic restrictions on an already precarious community;
- the increase in violence (including gender-based violence, and violence by the police); and
- challenges in accessing health services, including OAT.

At the same time, participants described some important positive innovations which should be continued, including flexibility in access to harm reduction services, and impressive mobilisation by community-led organisations and networks to meet the unprecedented needs.

Participants also reflected on the challenges with accessing funding for community-led organisations, with feedback for key donors.

These themes are discussed below in more detail before turning to the analysis.

1. Economic Impact of COVID-19

"People lost their jobs; people lost their families; people put off their health [needs]." (KII-6)

While the COVID-19 pandemic has had severe economic impacts on the population globally, these impacts have been felt especially deeply by people who use drugs, given the economic precarity of many community members. Over a quarter of study participants described the economic impacts of the COVID-19 pandemic.

Government-imposed COVID-19 restrictions, including stay-at-home orders and restrictions on travel and movement, stripped many people of their livelihoods and economic security. This was especially true for those working in the tourism industry and informal sector, including sex workers and others dependent on daily employment to meet their basic needs, according to participants in Africa, South-East Asia, and Europe (KII-1, KII-5, FGD1-N1). In coastal Kenya, FGD2-N3 said that the government's restriction-of-movement orders had a direct effect on the tourism industry, which many people who use drugs depend on for income. In the UK, the shutdown of the tourism industry impacted street-based communities of people who use drugs, who depend on begging or shoplifting to survive (KII-5). Across the African regional network, KII-1 said:

> *"First of all, we were seen as drug users; but second, we also violated the lockdown curfew. We have to move to go look for our drugs, we have to move to look for something to eat, to do a small job."* (KII-1)

The burden was even heavier for women who use drugs, according to several interviewees (KII-1, KII-2, KII-4). As KII-1 explained, many women who were the primary caregivers for children or other dependents were unable to provide without an income. When women who use drugs were incarcerated as a result of increased street-level policing, children were sometimes left alone. Women who engaged in sex work, particularly those working on the streets, were more visible targets for policing, and were left with fewer choices for clients; this resulted in greater risks of exploitation and abuse (KII-2, KII-4).

Interviewees described significant challenges with sustaining access to housing. In the UK, KII-5 reported that the government did successfully make housing available to many people who use drugs who needed it. In Canada and Australia, study participants said that governments initially did house people during the COVID-19 pandemic. Unfortunately, once COVID-19 restrictions were lifted and businesses reopened, in some cases, people were forced back out onto the streets (KII-8, KII-3). In Costa Rica, KII-4 said that although shelters were made available, as the pandemic continued, authorities shut down shelters and forced people to return to living on the streets, or in other precarious housing circumstances. In South Africa, KII-2 also said that shelters became available initially, but that the government did not appear willing to sustain them longer-term.

To mitigate the economic impact of restrictions, governments made some benefits available to those without employment. However, interviewees described these actions as insufficient and often not sustained long-term (KII-3, KII-2, KII-1). For instance, in South Africa, KII-2 said there was a small increase to an unemployment fund, but not enough to enable a person to survive for a month. The lack of sufficient, sustained support caused some to be unable to pay for essential services, like COVID-19 tests, which in Nigeria, cost FGD2-N1 between $50-$100.

The combination of loss of income and unstable or overcrowded housing left many people who use drugs on the streets and exposed to increased policing as well as increased risk of violence.

2. Policing, Violence, and Gender-based Violence

COVID-19 public health measures also impacted physical security: in many countries, there were more police on the streets during COVID-19 restrictions than normally. As a result, 29 percent of study participants described an increase in detention, arrest, and police abuse. A significant increase in gender-based violence (GBV) was widely reported by women who use drugs, who also lacked access to survivor-centered services.

Lockdowns and curfews imposed by governments left street-involved people more visible, and as a result they suffered from increased violence and police harassment (KII-1, KII-3, KII-4, KII-5, FGD2-N2). Participants also reported increased violence linked to the economic desperation experienced by many, including in some cases increases in local robberies among people who use drugs (KII-5). A participant in Kenya also described an increase in 'mob injustice' or vigilante violence targeting people who use drugs (FGD2-N3).

This included an increase in police abuse as part of enforcement of COVID-19 restrictions, which disproportionately exposed street-involved people who use drugs. Interviewees stated that authorities in the African and South-East Asian regions required people to carry documentation on them at all times, which some street-involved people lacked (KII-1, FGD1-N1). In South Africa, KII-2 described harassment by police during peoples' way to housing shelters after meeting their merchants or dealers.

In the U.K., KII-5 reported police using COVID-19 rules and regulations as an excuse to target and punish people who use drugs. This included unannounced 'welfare checks' at private homes, with fines for people who gathered to use drugs in violation of COVID-19 restrictions. In Australia, KII-3 recalled that the government locked down nine public housing towers in Melbourne with no warning, and a friend who had been visiting the housing complex to purchase drugs wound up trapped in the building for the duration of the lockdown. In Portugal, a study participant reported ongoing surveillance of women who use drugs by police who identified them and who continue to monitor them (FGD1-N4).

Police were often the main interface between the state and the community. KII-4 expressed frustration that governments increased policing instead of providing urgently-needed support:

> *"Governments don't go everywhere. You don't get health services going to crack houses, you know, or sex-working areas. At the end, it's the police that go there, and...their actions were more punitive and not ... health-oriented."* (KII-4)

Participants reported that police violence also increased (KII-1, KII-2, KII-3, KII-4, FGD1-N1). In the U.K., KII-5 reported that in some cases, police or security guards who avoided putting people in detention due to COVID-19 restrictions would instead use violence against people who use drugs as extra-judicial punishment for shoplifting. In Ecuador and Mexico, KII-4 reported hearing of police forcing people who use drugs to do excessive amounts of sit-ups or other exercise, and other abusive and punitive treatment on the streets.

Women who use drugs reported a sharp increase in GBV, whether by partners, other community members, or by law enforcement. Lockdowns, curfews, and business closures trapped women with abusive partners inside their homes with nowhere to turn for support (KII-4, FGD2-N4).

Four interviewees in the South-East Asian region, African region, and Costa Rica, said they witnessed significant increases in GBV, intimate partner violence, and stigma and discrimination (FGD1-N1, KII-4, FGD2-N1, FGD1-N2). A forthcoming EuroNPUD report on GBV during the pandemic details increased violence toward women who use drugs by partners, police, and others on the street.

A survivor-centered approach to GBV seeks to empower the survivor by centering their needs and preferences, and includes access to health care, mental health care, and psychosocial support, protection or security, and access to justice (UNFPA, 2012). However, participants said that the increase in GBV experienced by women who use drugs during COVID-19 was not addressed by increased medical or psychosocial support, and that survivors often lacked channels to report violence.

KII-1 explained that some African cases of GBV were documented, but many victims kept silent due to cultural norms. Another focus group discussion participant in the African region said that "there was a lot of rape and gender-based violence affecting women who use drugs", but that few women had access to sexual and reproductive health facilities as these had been repurposed for COVID-19 (FGD1-N7). As FGD2-N4 in the South-East Asian Region explained, when women who use drugs experience abuse, they often lack a channel to report these cases:

> *"Even awareness about what can you do, where can you go when such things happen... and making those services happen actually. It's really frustrating because there's nothing. I mean, where do you go? Who do you talk to? You go to the cops, and they say, 'Oh, sort it out yourself,' and you can't really go there because of the severe stigma and discrimination...You're automatically labeled as someone who doesn't deserve help, someone not worth it."* (FGD2-N4)

In South Africa, KII-2 said that although there were long-running campaigns and movements to end GBV with lots of publicity and activism, there remains a lack of real action.

3. Challenges in Accessing Health Services

Thirty-eight percent of participants described challenges in accessing health services, revealing the multiple impacts of living simultaneously with multiple pandemics (COVID-19, HIV, TB, and hepatitis C). Some challenges were due to widespread interruption of services during COVID-19 restrictions, and related supply chain disruptions. However, harm reduction services were sometimes deprioritised or shut down, with disastrous effects for those who relied on them. Participants also described the lingering impacts of health sector stigma and discrimination against people who use drugs.

For people living with HIV, or affected by TB or hepatitis C, health service disruptions could be disastrous. In Nigeria, India, and Kenya, participants decribed how restrictions on movement prevented people living with HIV and affected by TB from accessing treatment (FGD1-N1, FGD1-N7, FGD1-N8). With global supply chains disrupted, some countries lacked essential medicines; others hoarded their supplies, causing stockouts. For example, in Costa Rica, one participant described a lack of antiretroviral treatment, and noted that the Minister of Health had said all available funding had gone to the COVID-19 response (KII-4). In Australia, KII-3 shared that many services the community relied on – such as public showers, meals, and other basic needs -- were shut down during COVID-19.

In many countries, OAT and other harm reduction services were suspended during COVID-19, because they were not prioritised. In Georgia, the government shut down a take-away OAT programme; in Kazakhstan, access to methadone was interrupted for a month (KII-6). In the UK, pharmacy-provided needle and syringe programmes reduced their hours from five afternoons per week, to two afternoons per week; to facilitate social distancing, they moved their services outside in public view, making it more challenging for many to use the services (KII-5). In the United States, FGD1-N6 shared that their methadone clinic implemented telehealth services which enabled healthcare providers to work remotely, while still requiring patients to attend in-person appointments.

In Ukraine, according to KII-6, though community members tried to warn authorities of the potential for stockouts, procurement of OAT in advance of the conflict was not prioritised. Once the war started, the government lacked necessary supplies. People reduced their dosages to make supplies last longer, but when the stock levels returned to normal, doctors refused to return to prescribing the original dosages (KII-6).

In South Africa, an interviewee reported an insufficient supply of harm reduction supplies, including needles and syringes, and safe stimulant use packs were nonexistent (KII-2). In India, government stocks of methadone and buprenorphine which were supposed to last for one year, did not even last for seven months (FGD1-N9).

The lack of adequate supplies also extended to personal protective equipment (PPE) needed for COVID-19 prevention. KII-1 explained that although African networks received PPE from Frontline AIDS, the funding was not renewed, and people were left using ‘single-use’ items multiple times.

Where services were available, access was impeded by continuing stigma and discrimination affecting people who use drugs. Participants said those trying to access health services but who did not have access to a shower were stigmatised (KII-2). According to one participant, those previously identified by hospital staff as drug users were attended to last (FGD2-N1).

Fears of stigma and discrimination prevented many people who use drugs from getting vaccinated and accessing other essential health services. In Ukraine, people were required to provide personal information, including information about their health status, in order to register for the COVID-19 vaccine; but KII-6 said many community members were afraid to share this information. In India, FGD2-N4 explained that many peers have avoided vaccination so far, out of fear that healthcare providers will demand documentation they cannot provide.

As FGD2-N1 emphasised:

> *"Criminalisation has already prevented a lot of people from accessing services before the pandemic started."* (FGD2-N1)

CASE STUDY

Peer-led NSP. When the needle and syringe programme (NSP) in one city in the UK severely restricted their hours under COVID-19 restrictions and also began operating in a public space, one INPUD member feared a major HIV outbreak and thus moved into action. In a matter of weeks, they mobilised local drug suppliers and individuals whose homes were used for drug consumption, and together they started distributing approximately 1,500 needles and syringes per month. This peer-led intervention soon accounted for almost 60% of all the needles and syringes distributed in the local area.

While it was a success, the informal, spontaneous programme had not been formally negotiated with authorities. Two years later, local partners are coming together to negotiate how this programme will operate in the future. UK authorities are asking the network to teach them how to sustain their services, and new funding has emerged. A recent consultation between the P2PNSP and the local drug service has now turned the scheme into a sustainable partnership with the local peers being offered the chance to engage in a formal, incentivised peer work scheme so they can build on this spontaneous initiative.

4. Essential Role of Peer-led Services

While governments struggled to address the impact of the pandemic on livelihoods, housing, security, and health services in an unprecedented and historically significant mobilisation, community-led organisations filled the gap.

As FGD1-N5 explained, the lessons learned from the HIV epidemic and response efforts had prepared many community groups with the experience and knowledge necessary to mobilise quickly and provide services. Community-led organisations started peer-led harm reduction services, sharing health information, providing mental health and psychosocial support, and linking peers to services. In a number of countries, faced with stockouts and shutdowns of harm reduction programmes during COVID-19, numerous participants said that peer-led groups started new harm reduction programmes (KII-5, FGD2-N2, KII-3, KII-2). In the UK, South Africa, and Australia, community-led organisations described circumventing bureaucratic restrictions to do so (KII-5, KII-2, KII-3).

In India, community-led networks coordinated outreach with Naloxone and other supplies to prevent overdoses (KII-7). Canadian peer-led organisations established special transition houses for women who use drugs who engage in sex work, with support staff on-site to provide Naloxone, safe using supplies, and safe sex supplies (KII-8). In South Africa, a harm reduction centre set up during the COVID-19 pandemic mobilised peer educators on bicycles to do home deliveries (KII-2). Other study participants also described delivering methadone and buprenorphine (FGD1-N9, KII-8, KII-5).

Peer-led networks provided other essential health services. In India, peer-led networks delivered ARVs to the homes of people under COVID-19 restrictions (FGD1-N5) as well as PPE (KII-4, FGD2-N2). They provided online mental health counselling (KII-4), and mobile services to provide COVID-19 vaccines to people who did not want to go to vaccination clinics (KII-3). Interviewees described food distribution for those in need (KII-5, KII-4, KII-2, KII-7, KII-8), organising financial support (KII-7, KII-5), and linking people to housing (KII-8).

Peer-led networks also shared user-friendly information about COVID-19 and vaccines in one-page black-and-white leaflets that could be inexpensively copied and distributed, combating misinformation with accurate health information.

In addition, peer-led networks continued their normal work of educating members about drug policy and their rights, holding Q&A webinar sessions on decriminalisation, conducting OAT literacy and rights training (KII-5), documenting barriers and challenges with health services, and feeding this information back to health officials (FGD1-N3), as well as advocating with governments, UN agencies, and donor agencies. In some cases, they formed new alliances: KII-7 noted that prior to the pandemic, key populations in India did not have a common platform to collaborate at a national level, but one was created during the COVID-19 crisis.

For communities living in conflict-affected Ukraine, these extensive community systems put in place rapidly during the COVID-19 pandemic are now helping the community to survive the war. As Anton Basenko, a member of the Community Research Board, observed:

> *"All good and bad lessons learned from the adaptation of services and treatment, [including] HIV and harm reduction responses in times of COVID, later definitely helped Ukraine to be much prepared for the emergency caused by the war, and definitely could be used by other countries in other emergency reponses."*

This mobilisation in turn sparked ground-breaking innovations in larger health systems.

5. Harm Reduction Flexibilities and Other Positive Innovations

> *"I think the shifts in OAT potentially are very significant. I think now that ideas of choice, take-home, and understanding of what proper therapeutic alliances look like, I think that's a really strong advocacy thing that we need to push on with."* (FGD1-N3)

While many hardships spawned from the COVID-19 pandemic, over time, positive innovations also emerged. In several countries, harm reduction flexibilities of which governments had stated for many years would be impractical, if not impossible, were piloted successfully during the crisis. New collaborations between peer-led organisations and governments sprung up to meet new needs, including a COVID-19 quarantine facility managed collaboratively by health officials with an Indian network of people who use drugs.

Participants in Kenya, India, Australia, and the UK described innovations in harm reduction flexibilities, including the implementation of greater flexibilities and extended OAT take home doses (FGD2-N2, FGD1-N5, KII-3, KII-5). In India, people were allowed to take-home three days' worth of methadone doses on average; in two or three states, take-home doses increased to 20-25 days (due to the distance people were required to travel to collect their medication) (FGD1-N5). In Australia, take home doses increased from five to 14 days in some contexts (KII-3). In Canada, KII-8 described innovations which include prescription of medicalised safe supply, pharmacies starting to provide harm reduction and safe using supplies, and the availability of take-home Naloxone programmes. Although these flexibilities might have happened eventually, KII-8 explained the pandemic was the driver in their adoption.

KII-5 reported about one study where it was found that 70% of people who use drugs in Scotland reacted positively to take-home doses. KII-5 argued that by allowing the majority of the population to use a more flexible treatment system, healthcare providers have more resources to attend to the needs of the smaller group of people who benefit from in-person care.

While overall some participants saw growing recognition of these positive changes, in Australia and Canada, two participants said that their governments have pulled back on the number of take-home doses allowed (KII-3, KII-8).

In addition to take-home doses, interviewees also described other positive innovations by health systems during the pandemic. Two participants in Canada and Australia cited doctors offering telehealth appointments for those on OAT, an especially beneficial development for those who live in more remote areas (KII-8, KII-3). In Australia, healthcare systems also introduced flexibilities like 'third party pickup' of OAT for people with COVID-19 (KII-3) and mobile and home delivery services for people with chronic health issues and/or mobility problems.

In India, where peer-led networks were struggling to provide overdose treatment to peers in sometimes remote quarantine and isolation facilities, a community-led organisation was able to coordinate a specific COVID-19 quarantine and isolation space for people who use drugs. With the central facility, community-led organisations were able to provide buprenorphine and overdose medications to people who use drugs, and address other needs associated with withdrawal. To avoid added stigma, these separate centres were still labeled "COVID-19 isolation centres", but there was an understanding among the community and government that they were reserved for people who use drugs. Whenever people who use drugs were found in general isolation centers, it was understood that they should be transferred to the peer-supported centres (KII-7).

These and other innovations were facilitated in part by digital innovation, as much of the world shifted online during COVID-19 restrictions; though the digital transformation did not benefit all equally.

6. Digital Advocacy and Digital Divides

The COVID-19 pandemic sparked an unprecedented shift to online communication and meeting platforms, which brought new opportunities and challenges for networks of people who use drugs.

The shift was a boon for some aspects of network-building: as KII-8 described, it became easier than ever to connect with peers on different continents, to exchange experiences, to translate evidence-based knowledge, and to build the networks. KII-8's organisation realised the online shift offered an opportunity to reach community members in new ways, and created a video explaining how to 'virtually spot' someone online, so they do not need to use alone. Other organisations developed new approaches to working online: facing a challenging new climate for drug policy advocacy after UN meetings moved online, INPUD developed new training resources, such as an online high-level advocacy tip sheet (INPUD, 2022a).

However, the digital transformation deepened marginalisation for some. As noted above, a significant portion of the people who use drugs are street-based and lack mobile phones or smartphones. This digital divide leaves many people without access to health information or the opportunity to participate online (KII-1, KII-2, FGD2-N2, KII-4). It can also leave them cut off from networks. As KII-4 recalls:

> *"I remember, in a workshop we had at the beginning of the pandemic, a sex worker who was there...with this Nokia phone. It was like this really old phone that you couldn't get any WhatsApp or anything else. So definitely, definitely, [their access] is not the same."* (KII-4)

In order to mitigate the digital divide in Australia, one community-led organisation provided phone cards, calling credits, and in some cases, actual telephones for free of charge for people to have and use. However, as KII-3 reported, people who are living on the street may lose their cell phones or have nowhere to recharge batteries; so while "it is fine to give people a phone, but that does not fix everything" (KII-3). In response, some organisations reverted to using printed materials to communicate where people could go to wash their hands, get access to PPE, and find temporary housing accommodations (KII-4).

The COVID-19 pandemic highlighted the need for a more intersectional approach to developing peer-led services. For example, FGD1-N5 recalled that when some members from the transgender and MSM communities came forward to use their organisation's programmes during the COVID-19 crisis, it became apparent that they had previously not tried to access these services out of fear of discrimination:

> *"They have been using, but they had never come to our services because of the feeling that they would feel discriminated against....This was an eye opener for many of us, that there are many other community members from other key populations who are dependent on drugs, and they also need help. This is something that we should learn from the pandemic: How do we integrate services for transgender, for MSM, and also increase the number of programs for women who are into sex work as well as for women who are in the system?"* (FGD1-N5)

7. Financing Peer-led Organisations

> *"You need to have strong drug user networks established and present, because we step up when it matters. We have the capacity and knowledge to respond, but we are so poorly funded compared to professional drug services."* (KII-5)

While community-led organisations and services were the lifeblood of pandemic response efforts for the community of people who use drugs, they often remained underfunded. In most regions, participants described the crucial need for sustainable financing to ensure peer-led organisations have the capacity to respond in an emergency like the COVID-19 pandemic (KII-5, KII-2, KII-8, FGD1-N3).

Some donors tried to respond to this urgent need with emergency funds for peer-led networks. In South Africa, KII-2 described accessing emergency funding to meet community needs. In the AfricaNPUD reigon, KII-1 described a Frontline AIDS COVID-19 emergency fund for countries which enabled access to PPE and other support.

The Robert Carr Fund for Civil Society Networks (RCF) launched an Exceptional Opportunity Funding round, financed by the US President's Emergency Plan for AIDS Relief (PEPFAR), to fund regional and global networks of inadequately-served populations. The funding supported some peer-led networks to continue their work (KII-6). In another case, it supported peer-led networks to conduct a situational assessment of access to OAT before, during, and after the COVID-19 pandemic in Greece, Germany, England, and Scotland, documenting some breakthrough innovations that could be continued longer-term (KII-5; Shevchenko n.d.).

At a larger scale, the Global Fund COVID-19 Response Mechanism (C19RM) aimed to mitigate the impact of COVID-19 on the HIV and TB responses, but participants in the study described bureaucratic challenges with accessing this funding (See Case Study 2). According to KII-4, in Latin America, C19RM funding had to pass through many stages of consultation and other bureaucratic hurdles that slowed the process, leading to the funding being repurposed to meet other needs.

In Kenya, FGD2-N3 also encountered bureaucratic difficulties in distributing C19RM resources to peer-led organisations. Within the AfricaNPUD network, KII-1 reported that seven networks funded by the GF for harm reduction service delivery were unable to implement their grants due to bureaucratic barriers. In Eastern Europe and Central Asia, KII-G described encountering stigma and lack of empathy at the Global Fund Secretariat, and said that some staff gave the impression they were more concerned about reporting on HIV indicator targets than with meeting the needs of communities.

Participants expressed that in too many cases, donor imperatives were restrictive and did not align with the needs identified by communities on the front lines of the public health emergency (KII-6, KII-2, KII-4). For example, in Costa Rica, community-led organisations requested funding to provide mental health assistance to community members hit hard by the COVID-19 crisis, but funders limited the funding for shelters (KII-4). By contrast, in Ukraine, community-led organisations requested funding to provide permanent shelters to people who use drugs, but reported that funding was instead used for a large conference hosted by the donor (KII-6). Some donors favoured network growth and capacity-building, but communities lacked the infrastructure to enable them to meet: such as venues, computers, showers, and bathrooms (KII-2).

One deeply-felt frustration described by many interviewees, in the context of the crisis, was the lack of recognition of their own expertise as veterans representing community networks who knew what they needed and what worked. Numerous participants noted that people who use drugs are rarely paid a fair or consistent living wage in recognition of their expertise. KII-5 said:

> *"People would love us to set up networks all over the place. But we don't have money to do it. So, it's this sort of sense that their expectation is always that we will do the work for little to no money, while they expect to be paid all the time."* (KII-5)

CASE STUDY

Global Fund emergency funding slowed by bureaucracy. In one country with a high burden of HIV, communities came together with other partners to request emergency funding for people who use drugs for emergency costs — including livelihood support — during COVID-19 restrictions. After extensive negotiation among the partners and addressing government concerns, the Global Fund awarded a 10 million dollar grant to the national peer-led network.

The network successfully negotiated a key component of the grant to include direct disbursements of cash of approximately $20, or the equivalent amount in food rations, to those in need. In order to avoid fraud or waste, the principal recipients were required to collect information on each individual beneficiary, including bank account numbers and government-issued identity cards for tens of thousands of individuals.

However, many of the states where the programme was being carried out lacked community-led networks who could access the individuals. Furthermore, many people who use drugs do not have bank accounts or identity documents. Those who obtained the cash were sometimes unable to spend it on food, as many shops were closed during COVID-19 restrictions.

With limited resources, the principal recipients, based in the national capital, were able to collect information from some of the states, but not all. For this and other reasons, the two principal recipients were only able to spend approximately 25-30% of the grant. Moreover, they had to implement what was originally supposed to be a two-year grant in only one year. These challenges created numerous internal stresses that weakened the response during a crisis.

In order to prevent this negative outcome in a future health crisis, one study participant suggested that the Global Fund put appropriate partnerships in place with peer-led networks in advance, developing systems for accountability and reporting that are more appropriate to an ongoing relationship between a donor and grantee.

To promote equity, one network's board members decided that all positions would be paid a standard salary (KII-6).

Interviewees described all these frustrations as being all too familiar from pre-pandemic times. However, in the context of a crisis, these longstanding issues added unnecessary burdens that impeded community-led responses.

8. Pandemic Treaty - to Engage or Not?

Despite all these challenges, study participants overall expressed willingness to engage in the pandemic treaty process in order to continue to push for a meaningful dialogue about the needs of people who use drugs during public health emergencies (FGD1-N1, FGD2-N1). Several expressed interest in engaging in and learning more about the process. FGD2-N5 recommended INPUD to train and support more network members to engage with global governance stakeholders, and to improve and diversify the representation of people who use drugs in these spaces.

While understanding the process of developing the pandemic treaty may be a long and burdensome one for community representatives with limited bandwidth, KII-5 nonetheless emphasised that influencing global strategies can create real opportunities:

> *"We definitely took 10 years to get the stimulant guidelines... But now, we've got the guidelines. Now we're writing the training manuals, now we're coming around the world training people, and in the next round of the Global Fund, [work on] stimulants will be properly funded. So, I mean, these things do take place...*
>
> *"The UN is a bit like an oil tanker, it doesn't move very fast and turn very quickly. But once you get the momentum going in a particular direction, it's also quite hard to stop it."* (KII-5)

5. Discussion

These findings show that the COVID-19 pandemic further exacerbated the existing harms faced by people who use drugs globally and generated new forms of discrimination while also heightening inequalities. However, it also showcased the resilience and creativity of people who use drugs, the benefits reaped from hard work by many to build and rebuild institutions and networks in recent years, and showed again that consistent community mobilisation and innovation can save lives and mitigate the damage done by the pandemic.

Our findings show that many of the harms and challenges faced by people who use drugs during the COVID-19 pandemic were first and foremost a result of ongoing criminalisation, stigma, and discrimination. As Malinowska-Sempruch and Lohman (2022) emphasise, "the public health community needs to mobilise against attempts to persist with a fundamentally flawed drug policy approach". Criminalisation exposed people who use drugs to some of the most severe economic impacts of the pandemic, particularly for those in the informal economy and those who were street-involved. Expansion of police powers led to increased harms, as increased visibility due to lockdowns and stay-at-home orders made the community vulnerable to arrest and abuse. The stigma towards and discrimination against people who use drugs born from criminalisation created a multitude of challenges for the community when trying to access health services. For many people, essential services were either entirely shut down, as they were seen as not a priority, or individuals themselves were neglected in waiting rooms and health clinics by doctors who knew their status.

Our findings also show the disproportionate burden on women in their diversity, including due to increased gender-based violence. Like drug use, gender-based violence is widely stigmatised and taboo. Like harm reduction services, survivor-centred services for victims and survivors of violence are rarely prioritised as essential services in a crisis. Existing gender inequality was deepened by the pandemic, and states were clearly unprepared to address the needs of women who use drugs. This was consistent with wider documentation of an increase in gender-based violence linked to stay-at-home restrictions, with persons at risk of violence exposed to increased control and restrictions by their abusers having little or no recourse to seek support (OHCHR, 2020).

At the same time, we find real innovations and new partnerships developed in the crisis among communities as well as between community-led organisations and governments or international organisations. Where government intervention and services fell short or vanished completely, community-led organisations filled this void by creating and implementing peer-led services, which were absolutely vital in promoting the health and wellbeing of people who use drugs. Previous efforts to assess pandemic preparedness and response foundered on a lack of assessment of public trust in institutions, including the health sector; however, community-led responses can address this trust deficit, establish lines of communication, and reach marginalised groups most at risk of an outbreak (Byanyima et. al. 2022).

These findings also show how innovative approaches to harm reduction services like OAT take-home doses, needle and syringe programmes, and overdose treatment medications may have created new pathways to more flexible and sustainable health care in the future; these were the gains that must not be rolled back. There were other positive innovations which emerged and should be sustained, from the increased number of take-home doses that many governments have authorised, to new approaches like virtual spotting to prevent overdoses. These as well as other changes will require ongoing advocacy, including strengthening the funding mechanisms that make them sustainable.

Moving forward, specific tangible actions that INPUD can take to build advocacy and engagement include: 1) issuing additional statements and recommendations for language in the treaty; 2) engaging with member states, UN agencies, civil society, and community partners, such as the Civil Society Alliance for Human Rights in Pandemic Treaty (CSA); 3) urging UNAIDS to support meaningful consultation with communities; 4) pressing for seats in the treaty oversight mechanisms; 5) developing proposals for meaningful representation mechanisms; 6) pressing for more meaningful consultation at national levels; and finally, 7) looking for opportunities to give plenary talks or host side events, such as during the upcoming World Health Assembly in May 2023. A set of proposed recommendations, based on discussion with study participants, follows.

6. Conclusions

The COVID-19 pandemic highlighted inequalities and political fault lines at a global scale, with those most impacted being criminalised populations. Not only was the community of people who use drugs more vulnerable because many community members have underlying health issues; the community's very status as criminalised, stigmatised, and marginalised populations meant that the community was exposed to some of the worst harms of the pandemic and its response, including harm to economic survival and loss of housing, exposure to violence and punitive enforcement of restrictions, gender-based violence, and loss of essential access to health services. People who use drugs were left to cope with not just one pandemic, but multiple simultaneous pandemics, while services were often suspended or reduced.

The COVID-19 pandemic demonstrated that investing in the formal health system is crucial, but that on its own, it is not enough to ensure health. In countries where inequities were high, most people chose to fulfil their basic rights to food, income, and clean water first, even when this exposed them to risk of COVID-19 transmission, fines, arrests, or abuse. This points to the need to consider health within the larger frame of rights, equality, and dignity.

At the same time, the community of people who use drugs responded with unprecedented mobilisation, solidarity, and innovation. As a result, policy innovations that had previously been rejected as impossible were suddenly implemented. Saving lives, including those of people who use drugs, was suddenly prioritised; and policy challenges were bypassed in order to respond to urgent threats. Policies and regulations, such as take-home OAT doses, were improved almost in real-time. Some countries saw de-carceration efforts, including for drug offences; others saw rapid conversion of hotels into shelters. Experimentation with everything from peer-supported quarantine to bicycle home delivery of OAT was suddenly a reality. While digitisation meant that many were cut off by the digital divide, it also facilitated new solidarities and new alliances across national boundaries.

These innovations and partnerships have already made the world better prepared for the next crisis. In Ukraine, HIV and harm reduction lessons learned during the COVID-19 pandemic helped create a more resilient community system that was better able to respond to wartime. The traditional health system by itself has demonstrated it cannot respond effectively to a fast-moving crisis. It lacks flexibility; it cannot adapt in real time. The harm reduction and drug users' movement provide an opportunity for health systems all over the world to extend their reach and truly reach the last mile. Investing in harm reduction and the drug users movement is an investment not only in a sensible drug policy, but also in human rights, gender equality, and the right to health for all.

7. Policy Recommendations

Drawing upon the findings from the research process, interviewees from both the key informant interviews and focus groups discussions developed a set of recommendations for INPUD to advance in the pandemic treaty discussions, including:

1. **Call for the zero draft of the Pandemic Treaty to clearly reference the *Universal Declaration of Human Rights* and core international human rights instruments, including:**
    - Non-discrimination, including based on 'other status', in line with the wording of Article 2(1) of the *International Covenant on Economic, Social, and Cultural Rights* and Article 2 of the *Universal Declaration on Human Rights*;
    - Reference to the right to the highest attainable standard of physical and mental health, including non-discrimination, availability, accessibility, acceptability, and quality in line with, inter alia, General Comment 14 of the Committee on Economic, Social, and Cultural Rights;
    - Reference the right to the underlying determinants of health, including access to housing and safe drinking water;
    - Reference to government obligations to protect against abuses by non-state actors, as well as companies' responsibility to respect human rights;
    - Reference to states' obligations to guarantee the rule of law, as a principle of governance and a precondition to the effective protection of human rights, including in the context of a public health emergency PPRR;
    - Reference to the human rights provisions applicable during states of emergency as codified in the Siracusa Principles, including the principles of legality, necessity, and proportionality. The treaty should protect individuals from threat of criminal sanctions linked to infection and reaffirm clear limits on restrictions of rights during an emergency;
    - Uphold the right to privacy; and
    - Reference the need to commit to human rights principles of transparency and accountability at all levels, and to community-led monitoring to ensure social accountability.

2. **Call for meaningful participation of communities in the pandemic treaty negotiations and in future oversight, including through civil society representation on the E-COP; as well as meaningful involvement with Universal Health Coverage and PPRR coordination bodies.**
    - While the negotiation process is led by member states, the history of widespread criminalisation, stigma, discrimination, and neglect, as well as the disproportionate impact of the COVID-19 pandemic on people who use drugs, means that they must be able to meaningfully represent themselves at all levels of pandemic prevention, preparedness and response.

- Affirm that because of this, community representation addresses a democratic deficit in global health governance and it is thus more legitimate than and distinct from the promotion of private interests by the private sector. Their roles should not be conflated with 'non-State actors'.

3. **Call for full decriminalisation of drugs**

4. **Call for the pandemic treaty to recognise community system strengthening as integral to health system preparedness.**

   - Develop and/or strengthen protocols/standard operating procedures (SOPs) delineating roles and responsibilities, focal point persons, and regular channels of communication and accountability to improve ongoing working relationships and resolve challenges between donor agencies and peer-led networks at global, regional, and country levels.
   - Commit to ongoing strategic consultations with key population networks to resolve key challenges and support meaningful engagement of community-led networks, including within political constraints and criminalised contexts.

5. **Call for pandemic financing mechanisms to include long-term and sustainable financing for community-led networks, strong transparency and accountability mechanisms, as well as independent whistleblowing mechanisms.**

   - Ensure sustainable funding for community-led networks to prepare for future emergencies, recognising that past investments in community infrastructure for the HIV response have proven to have been integral to the COVID-19 response.
   - Pandemic financing mechanisms should commit to respect for human rights in their financing and to respecting, protecting, and providing access to remedy for human rights abuses linked to implementation of financing.
   - Vertical donor-driven funding leads to fragmentation and lack of country ownership. As such, funding must be driven and co-designed with communities in countries where funding will be deployed.
   - Take steps to reduce bureaucratic hurdles for crisis funding for communities.

6. **To prevent, prepare for, and respond to gender-based violence, there is a need to expand availability of alternative accommodation to enable victims/survivors to avoid confinement with abusers, and put in place accessible, diversified, and proactive systems to enable victims/survivors to access survivor-centred response services.**

   - These should include medical care, mental health care and psychosocial support, protection services, and access to justice.

7. To fulfill the right to health for people who use drugs.

- Ensure access to safe, regulated drug supply and safe using supply.
- Provide safe, supervised consumption sites in an emergency (incl. in emergency housing or shelters).
- Address the digital divide: ensure access to health information for people without smartphones or WiFi access.
- Declare harm reduction services and gender-based violence-related services as essential activities, and to remain available during lockdowns.
- Ensure accessible, affordable, and acceptable access to core harm reduction services including instituting use of take-home doses for OAT and ensure access to overdose treatments.
- Prepare drug stocks (supply chain, transport, and logistics) to ensure no stockouts.
- Train and hold healthcare providers accountable for ethical and rights standards, including non-discrimination.

8. Recommendations to civil society and community networks:

- Advocate for full decriminalisation and support for harm reduction policies and programmes;
- Support exchange of experiences among networks, community-led organisations;
- Support development of capacity and skills for grant management and leadership;
- Study, document, and advocate for the political space needed for community needs, inputs, and perspectives to feed into national, regional, and global responses;
- Provide harm reduction information specific to health emergencies and outbreaks, as was done during the COVID-19 pandemic; as well as OAT literacy and rights information for community members to use in advocacy in a street-friendly health info;
- Develop pandemic-specific harm reduction information for people who use drugs;
- Collate and share community feedback on emergency services;
- Support and train INPUD member networks to represent community in diverse spaces; and
- Bring study findings to the attention of the UN Office of Drugs and Crime (UNODC) and participants in the International Network of Health and Hepatitis in Substance Users (INHSU).

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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 its 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. www.inpud.net

INPUD would also like to acknowledge people who use drugs around the world who fight back against criminalisation, stigma and discrimination, harassment, abuse and violence every day. We will continue fighting to change existing local, national, regional and international drug laws and formulate an evidence-based drug policy that respects people's human rights and dignity instead of one fueled on moralism, stereotypes and lies.

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