From evidence to essential services: embedding harm reduction in national health systems

12 May 2026

World Health Organization
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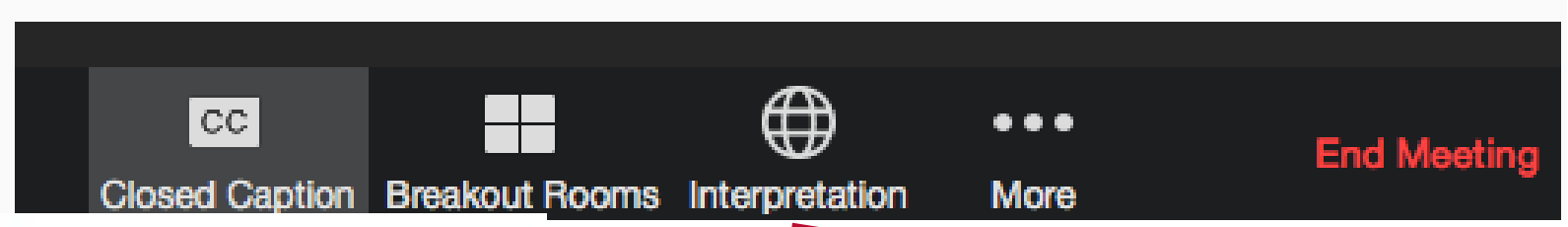
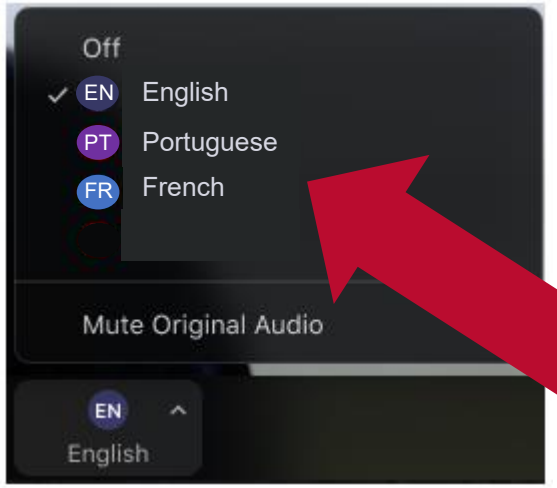
How to join audio interpretation line





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Housekeeping

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Engage with questions using the chat box!	For general comments, use the chat box to all panelists and attendees
	For specific questions to presenters and panelists, use the Zoom Q&A box

Housekeeping

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- Presentation slides and recording link will be shared by email for those who registered after the session.

To our presenters and speakers

Please keep to time allotted

Speak slowly and clearly

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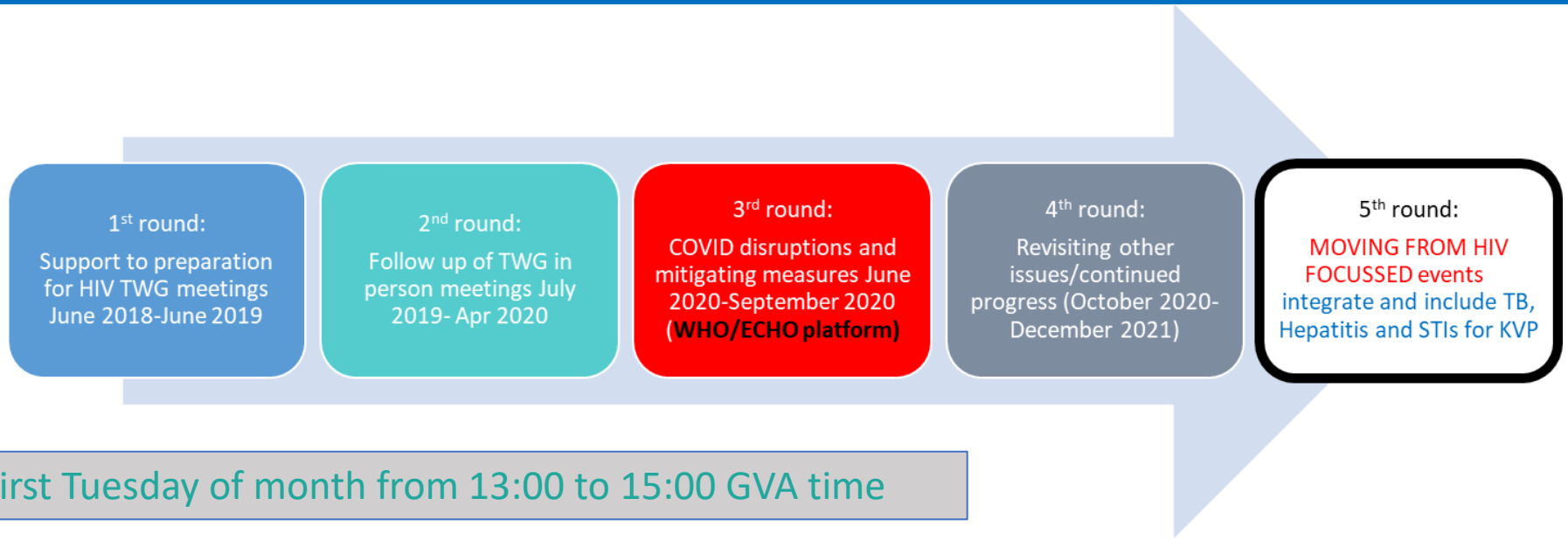
Objective of WHO KVP TeleECHO™ Sessions



Bi-monthly on first Tuesday of month from 13:00 to 15:00 GVA time

Information sharing and interactive discussion

Progress and pending issues on scaling up services for key and vulnerable populations for HIV, TB, Hepatitis and STIs

Flag challenges, share solutions and trigger technical assistance

Overall goal is to flag challenges, share solutions and trigger technical assistance by various stakeholders at global or regional level

These webinars are a platform to showcase, learn, inform and discuss. They do not represent an endorsement of shared experiences and practices.

Agenda

Chair: Catherine Cook, Harm Reduction International

13.00 – 13.05 (5 minutes)	Opening and housekeeping	Wole Ameyan, WHO HQ, Switzerland
13.05 – 13.10 (5 minutes)	Community introduction remarks	Anton Basenko, INPUD
13.10 – 13.25 (15 minutes)	From principles to practice: delivering WHO-recommended harm reduction for HIV, hepatitis and TB	Antons Mozalevskis, WHO HQ, Switzerland
13.25 – 13.40 (15 minutes)	Global State of Harm Reduction: progress, funding gaps and policy trends + “The Cost of Complacency: A Harm Reduction Funding Crisis”	Gaj Gurung, Harm Reduction International
13.40 – 14.10 (30 minutes)	Country implementation snapshots. How countries are embedding harm reduction into national systems	Moderator: Stela Bivol, WHO Europe Kenya: Barbara Mambo; Morocco: Ibtissam Khoudri; Portugal: Filipa Costa
14.10 – 14:15 (5 minutes)	Country panel Q&A	As above
14.15 – 14.45 (30 minutes)	Interactive partner panel discussion: Overcoming barriers and sustaining services	Moderator: Niklas Luhmann, France Ahmed Said, AfricaNPUD; Gorica Popovic, UNODC; Maria-Goretti Loglo, IDPC; Matteo Cassolato, The Global Fund
14.55 – 15.00 (5 minutes)	Closing reflections and next steps	Antons Mozalevskis, WHO HQ, Switzerland

From principles to practice: embedding WHO-recommended harm reduction into national health systems

12 May 2026

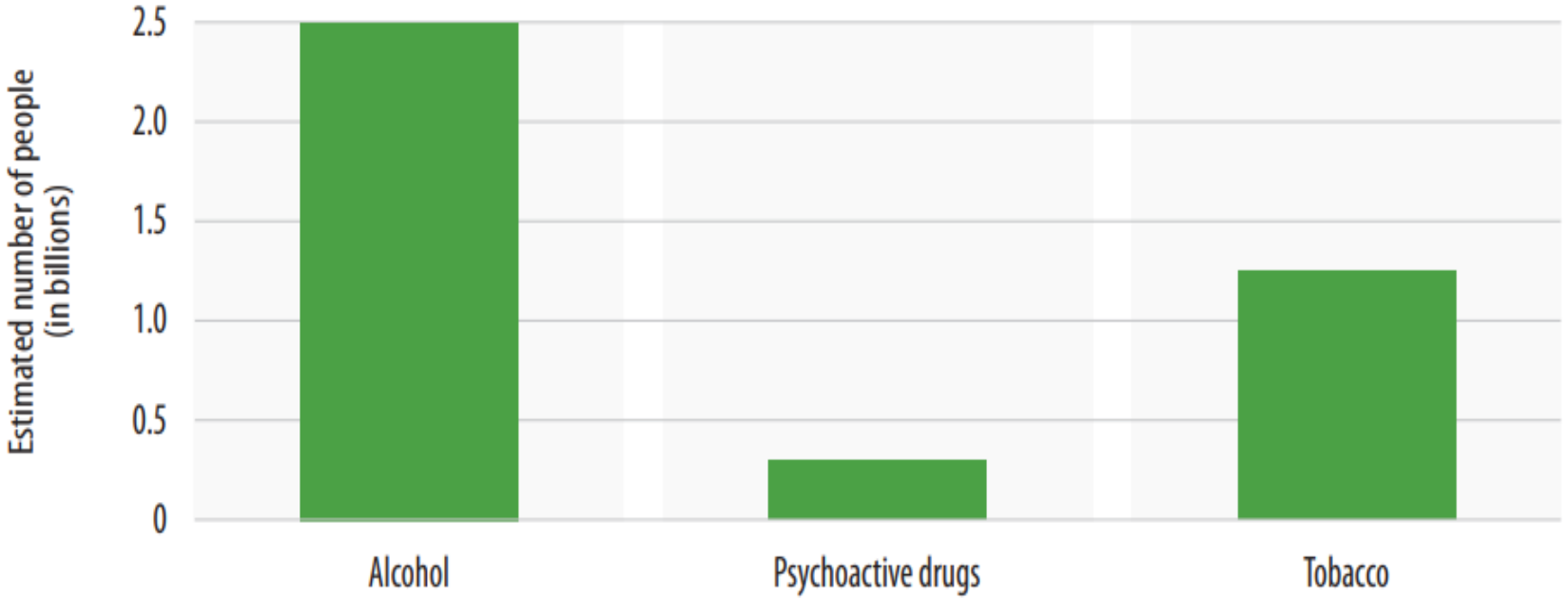
Dr Antons Mozalevskis

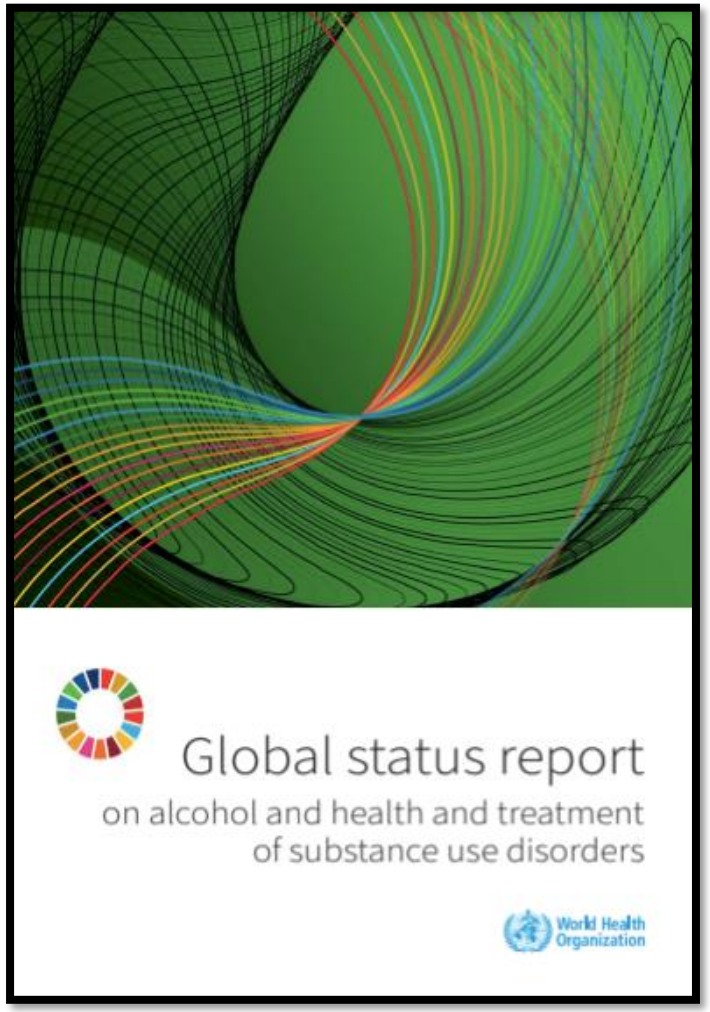
Department of HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections

WHO Headquarters

World Health Organization

Use of psychoactive substances





Estimated number of people:

- Alcohol: 2.5 billion
- Tobacco: 1.3 billion
- (Illicit) Drugs: 0.3 billion

Deaths attributable to drug use (2019)*

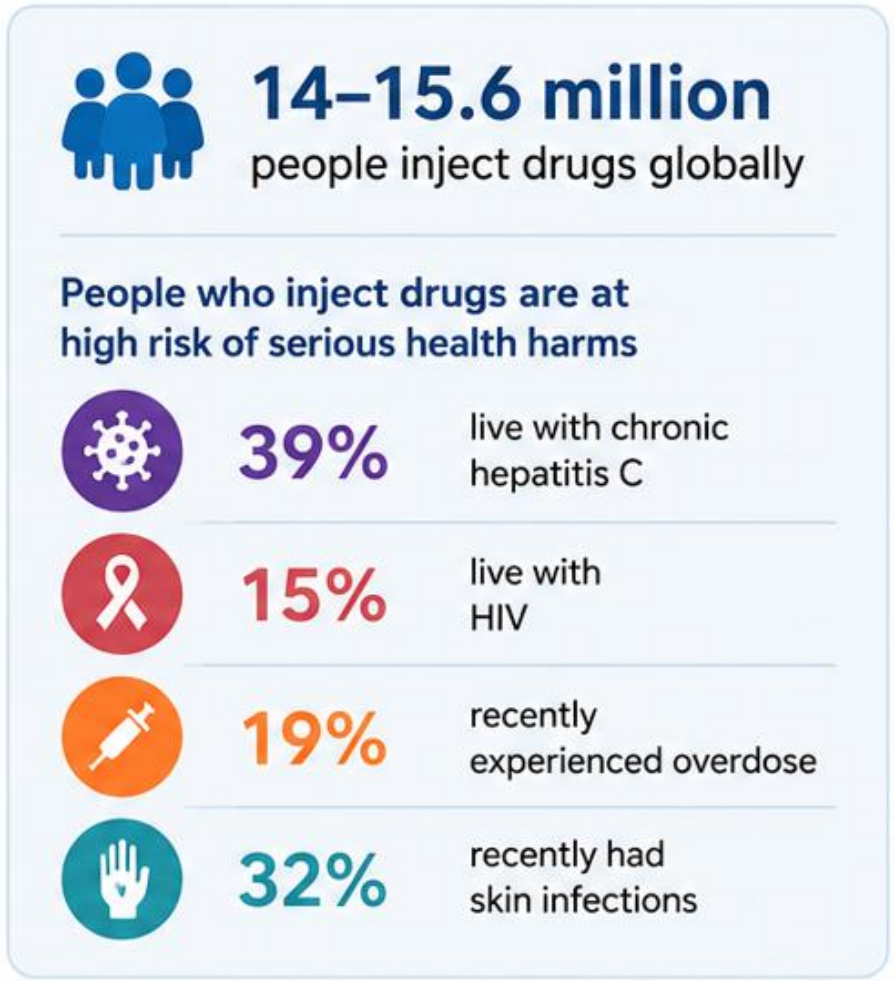
World Health Organization

Drug type	Drug use disorders	HIV	HBV	HCV	RTA	Suicide	Total deaths
Opioid	123 848	60 679	7 287	233 941	5 351	17 383	448 489
Cocaine	7 420	2 589	258	8 789	2 285	4 741	26 082
Amphetamine	4 454	5 427	666	21 345	9 214	5 555	46 661
Cannabis	–	–	–	–	14 206	–	14 206
Other	46 035	346	56	1 637	–	–	48 074
All drugs	**181 758**	**69 040**	**8 267**	**265 711**	**31 056**	**27 679**	**583 511**

Over half a million deaths attributable to drug use in 2019, the majority associated with hepatitis C followed by drug use disorders (mainly opioid overdose)

***Update planned for 2025**

The global health burden among people who use drugs



Source: WHO. Needle and syringe programmes for people who inject drugs: operational guide. 2025.

**People who use drugs are disproportionately affected by TB, but TB programmes have largely failed to adapt services to their realities and needs.*

What is harm reduction and what is WHO's position?

"A public health and human rights-based approach to reduce health and social harms of drug use – without necessarily requiring abstinence."

WHO HARM REDUCTION PACKAGE

Evidence-based services to reduce health and social harms of drug use

CORE 3 INTERVENTIONS

1. NEEDLE AND SYRINGE PROGRAMMES (NSP)

- Provide sterile injecting equipment and safe disposal
- Prevent HIV, HCV and other blood-borne infections

2. OPIOID AGONIST MAINTENANCE TREATMENT (OAMT)

- Methadone or buprenorphine for opioid dependence
- Reduces overdose, HIV/HCV transmission and criminal activity; improves retention in care and social functioning

3. OVERDOSE PREVENTION AND MANAGEMENT (NALOXONE)

- Provide naloxone and training to prevent fatal overdose
- Saves lives and connects people to care and treatment

ADDITIONAL SERVICES

HEALTH CARE SERVICES
HIV, HCV, HBV, TB testing, treatment and prevention; wound care; vaccination; sexual and reproductive health; mental health; primary care

PSYCHOSOCIAL SUPPORT
Counselling and peer support; social assistance (housing, legal aid, employment); linkages to community and social services

INFORMATION, EDUCATION AND COMMUNICATION
Drug use, safer injecting and sexual health information; stigma reduction; rights and empowerment

LEGAL AND HUMAN RIGHTS SUPPORT
Access to legal services and support to address discrimination, stigma and human rights violations

COMMUNITY LEADERSHIP AND INVOLVEMENT
Meaningful involvement of people who use drugs in design, delivery and monitoring of services

MONITORING, QUALITY AND SUSTAINABILITY
Data for decision-making, quality improvement and integration into health systems and sustainable financing

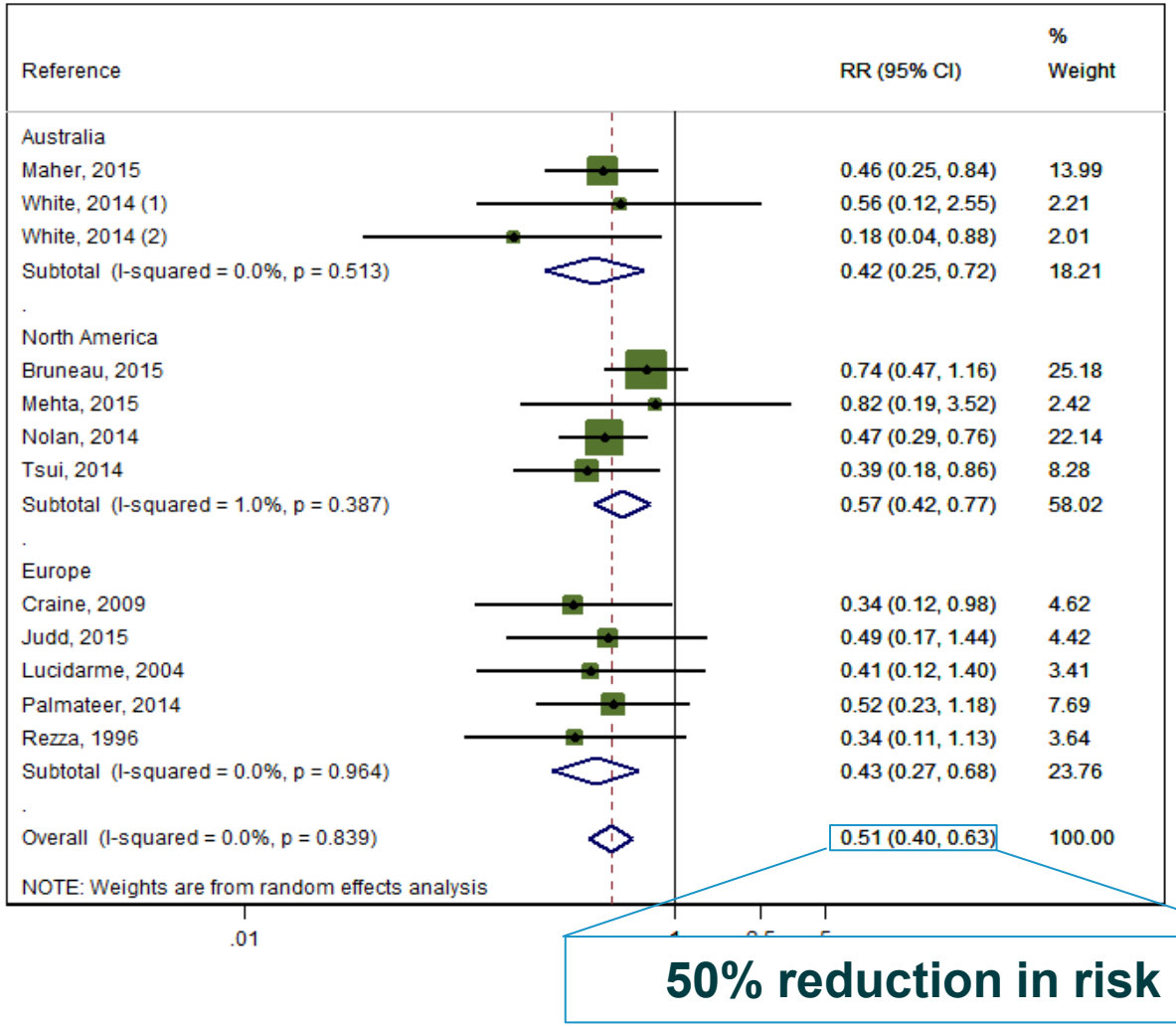
Person-centred • Rights-based • Non-judgmental • Evidence-based • Community-led • Integrated into health systems

Source: WHO. Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs. 2022.

Combining OAT and NSP increases impact: HCV transmission

World Health Organization

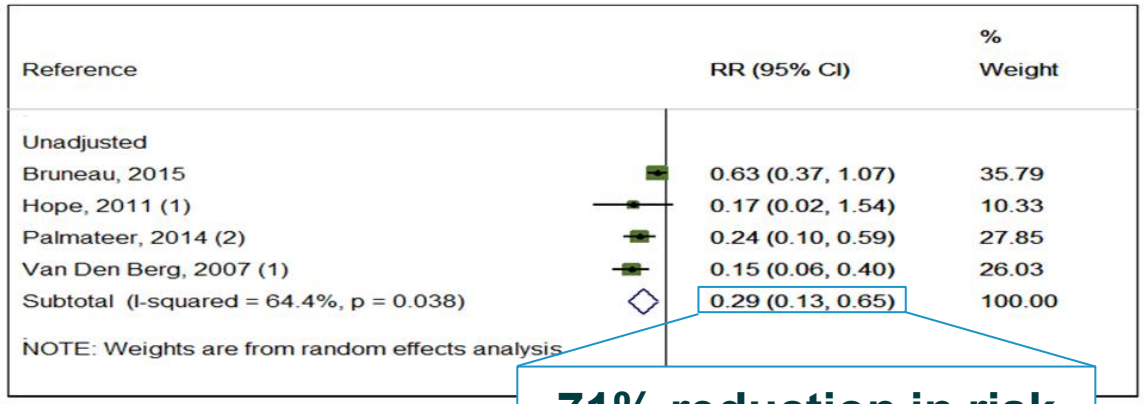
OAT (methadone/buprenorphine)



50% reduction in risk

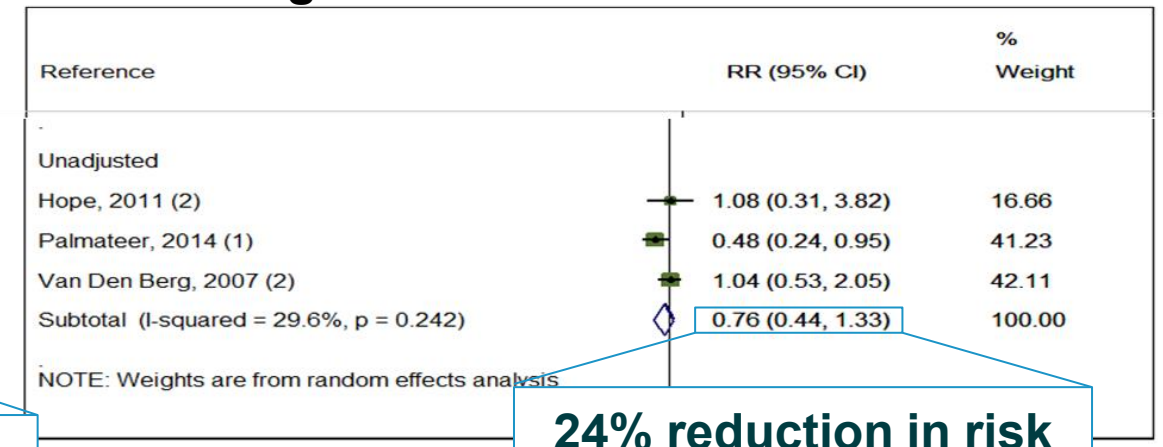
OAT/NSP

High coverage NSP



71% reduction in risk

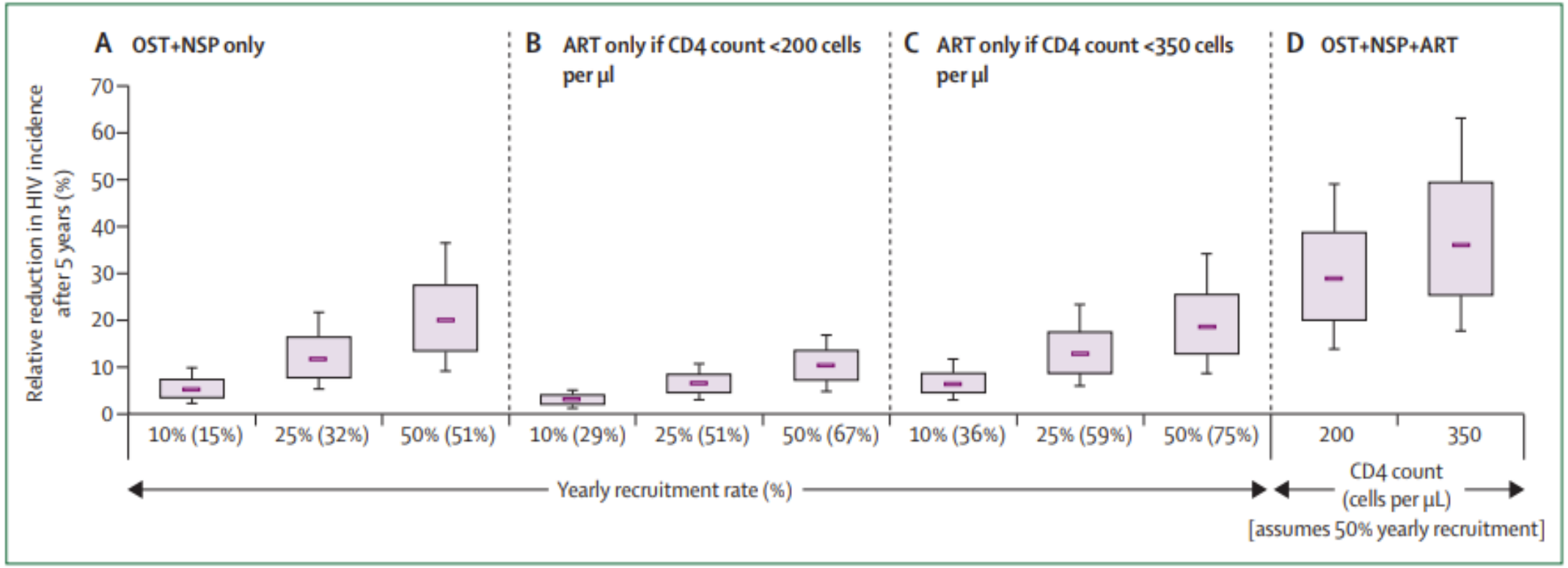
Low coverage NSP



24% reduction in risk

Platt L, et al. *Addiction* 2018

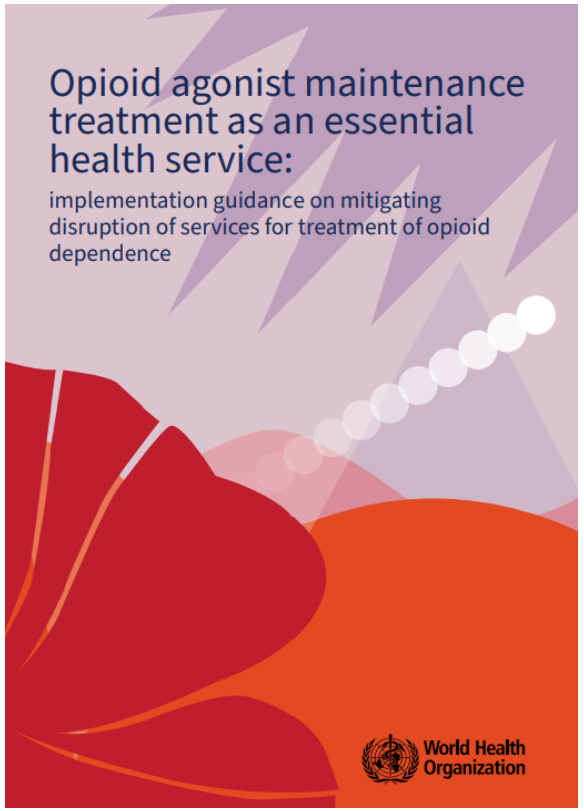
Combining OAT and NSP increases impact: HIV transmission



Degenhardt, Louisa, et al. "Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed." *The Lancet* 376.9737 (2010): 285-301

Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, Maher L, Palmateer N, Taylor A, Bruneau J, Hickman M.
Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. Addiction. 2018 Mar;113(3):545-563. doi: 10.1111/add.14012. Epub 2017 Oct 23. PMID: 28891267; PMCID: PMC5836947..

New implementation guidance from WHO (2025)



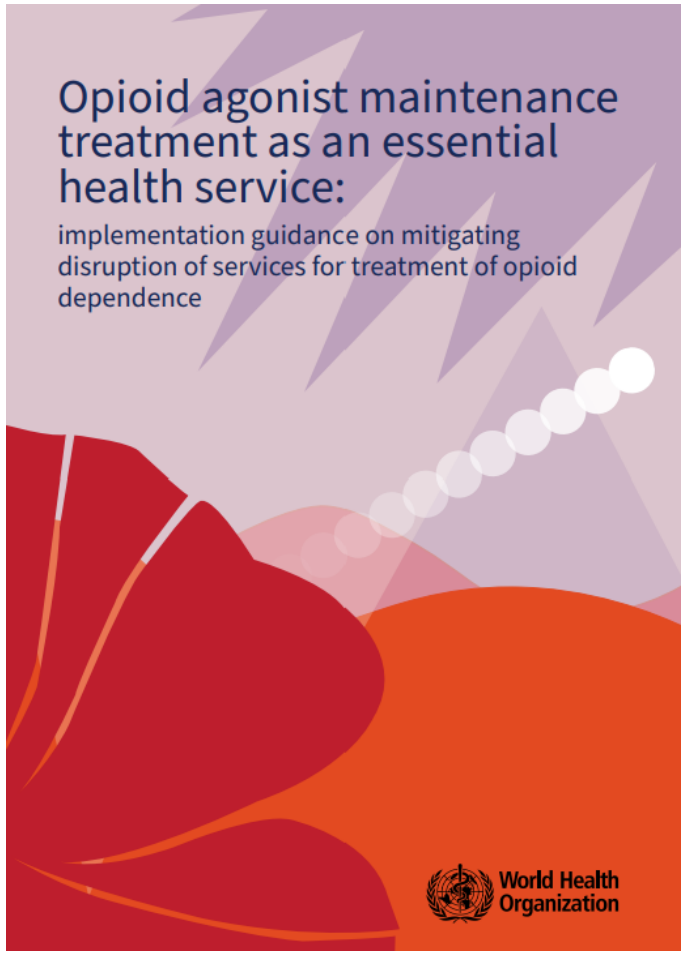
https://www.who.int/publications/i/item/B09543

https://www.who.int/publications/i/item/9789240116214

Key takeaways: WHO's guidance on maintaining opioid agonist maintenance treatment during emergencies | INHSU

Key takeaways: WHO's revised operational guide on needle and syringe programmes | INHSU

Implementation guidance: OAMT service disruptions (2025)



https://www.who.int/publications/i/item/B09543

WHO recommends that OAMT be used for most patients with opioid dependence, as it is the intervention for which there is the strongest evidence of effectiveness for a broad range of health and social outcomes

The sustainability of OAMT in public health structures is critical to protecting lives and preventing death from overdose

Involuntary or unplanned interruption of OAMT may have life-threatening consequences and must be avoided

When unplanned interruptions in OAMT are expected, contingency measures should be implemented as early as possible to minimize potential negative consequences.

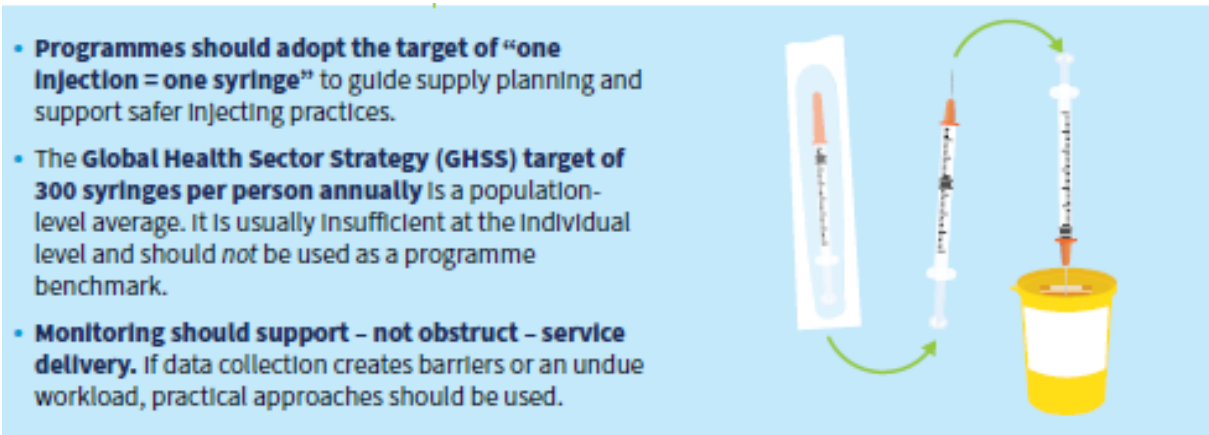
What the new NSP guide emphasizes

Five modules for implementation

1. **Assessment & planning** — population size, local drug use patterns, injection frequency, needs
2. **Implementation models** — outreach, fixed sites, pharmacies, peer-led distribution
3. **Comprehensive services** — linkages to OAMT, overdose prevention, HIV/HCV testing and treatment
4. **Monitoring** — community-led monitoring, quality, coverage
5. **Scaling up & sustainability** — political endorsement, domestic financing, integration into health systems

Guiding principles:

- Human rights–based
- Community-led
- Adaptable to local contexts
- Centre equity & inclusion.



World Health Organization

Peer-led NSPs are highly effective and essential for trust, reach, and sustainability.

The 2025 funding crisis and its impact

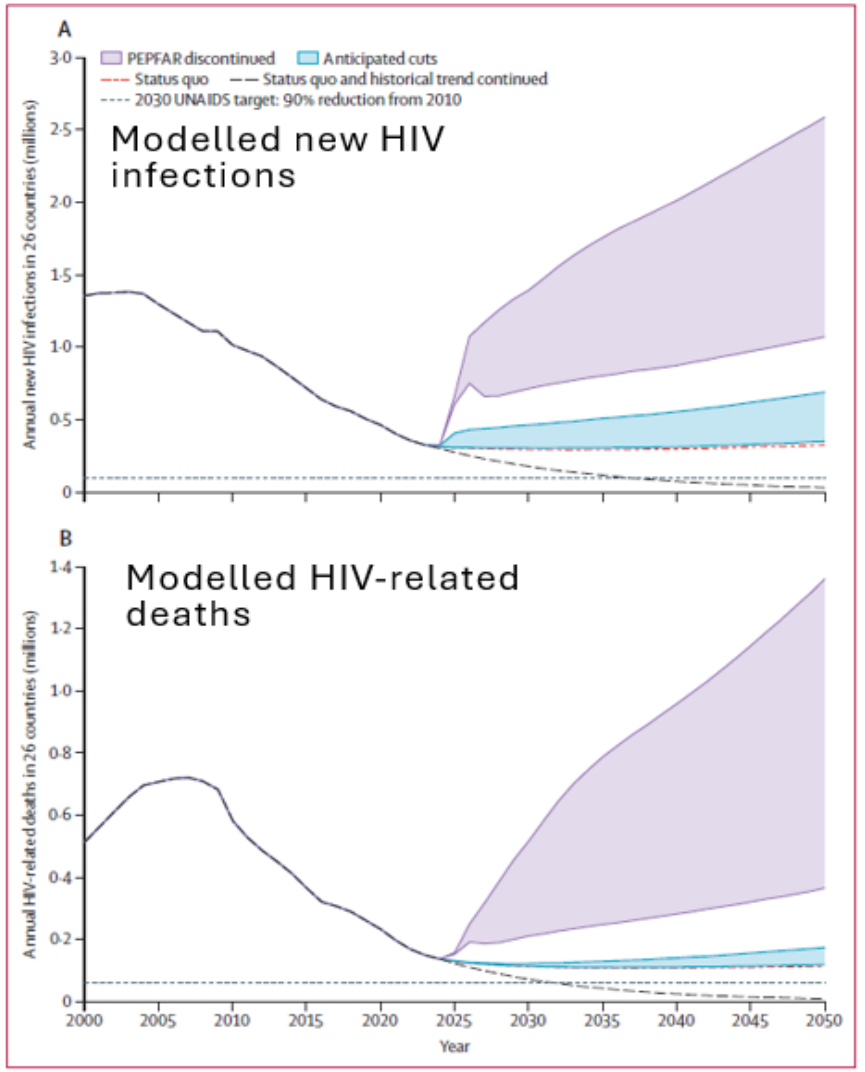
***based on WHO rapid stock-taking in March-April 2025**

- Sudden reductions in global health ODA in 2025
- 70%+ countries reporting service disruptions
- Stock-outs of HIV/OAMT medicines (1/3 countries)
- Disproportionate impact on key populations
- Modelling: millions of additional infections/deaths

World Health Organization

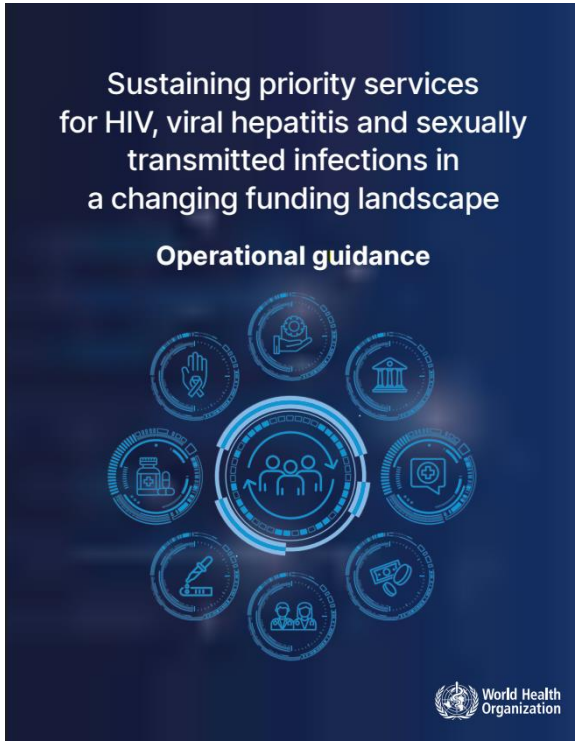
4.4 to 10.8 million additional new HIV infections by 2030

770,000 to 2.9 million additional HIV-related deaths by 2030



Brink et al, Lancet HIV, March 2025

July 2025:



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PREVENTION

TIER 1: ESSENTIAL		TIER 2: IMPORTANT	
Interventions	**Key rationale and decision-making notes**	**Interventions**	**Key rationale and decision-making notes**
Prevention of mother-to-child transmission of HIV, hepatitis B and syphillis (includes PrEP)	Critical for elimination of vertical transmission; integration enhances service delivery	Pro-exposure prophylaxis (PrEP) - including long-acting PEP ⇄	Should be made available and accessible, particularly for **key populations and those already on PrEP. Delivered through community networks**
HIV post-exposure prophylaxis (PEP)	Critical intervention, not limited to occupational settings **and delivered through community networks**	Voluntary medical male circumcision (VMMC) ⇄	Rec for 15 high-priority countries in East/South Africa; Tier 2 overall, elevated to Tier 1 in priority contexts
Blood product safety of a functioning health system and health care infection control)	Foundational component Blood product safety of a functioning health system ⇄	Vaccination for HBV ⇄	**Birth vaccination should be prioritized;** adult catch-up tailored to context and resources
Harm reduction services (including OAMT, needle and syringe programmes and naloxone provision for opiod overdose management)	Moved to Tier 1 in countries where already implemented; interruptions carry significant risks		
Provision of condoms and lubricants	Important for primary prevention, especially among key populations		

⇄ Indicates movement between tiers depending on contextual and population needs factor

★ **Harm-reduction services (including opioid agonist maintenance therapy, needle and syringe programmes and naloxone provision for opioid overdose management)**

The expert group classified this intervention as tier 2, acknowledging the equity value of these interventions while also considering feasibility and legal barriers within their contexts as very difficult. However, the WHO Steering Group had noted the need to upgrade it to tier 1 – especially for the settings in which these programmes already exist. Continuing opioid agonist maintenance therapy for clients who have been enrolled in the programme needs to be considered lifesaving since sudden disruptions of opioid agonist maintenance therapy may result in immediate increased mortality.

Embedding harm reduction services into national health systems could improve resilience during funding crises

World Health Organization

Donor funding is shrinking and unpredictable.
Integration strengthens national systems to keep life-saving harm reduction services running.

FUNDING CRISIS = HIGHER RISK

- Decreasing and unpredictable donor support
- Service interruptions and programme cuts
- Stockouts of OAMT, NSP, naloxone and other supplies
- Reduced outreach and peer workforce capacity
- Increased risk of overdose, infections and mortality

INTEGRATION BUILDS RESILIENCE

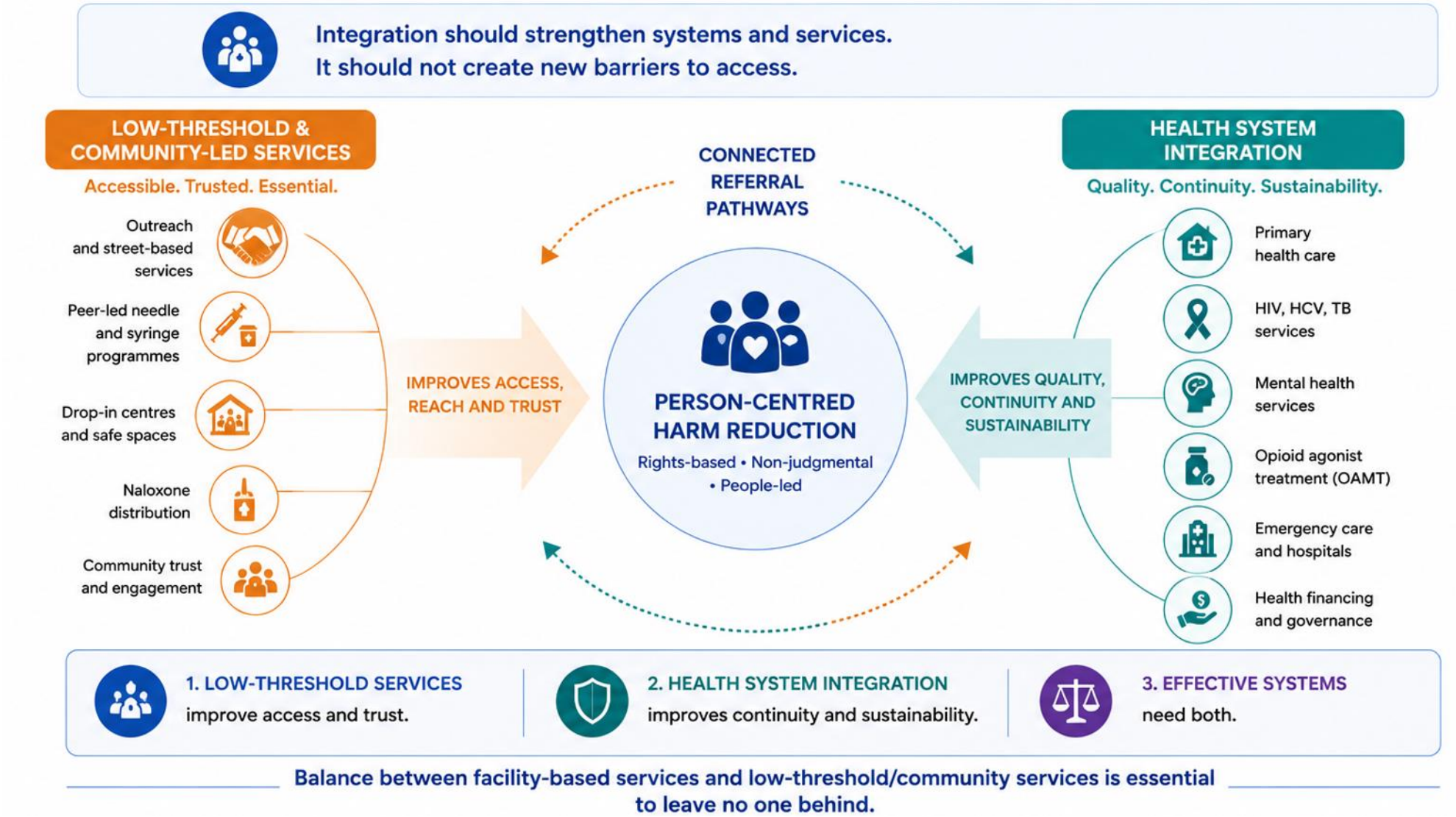
INTEGRATED SYSTEMS MITIGATE DISRUPTIONS

- Domestic financing and budget inclusion
- Embedding in primary health care and national services
- Stronger procurement and supply chain systems
- Sustained support for community-led and outreach services
- Inclusion in preparedness and emergency response plans

WHY IT MATTERS

- Protects continuity of essential services
- Saves lives and prevents setbacks
- Strengthens health system resilience
- Reduces long-term costs and harms

Harm reduction services must be integrated without erasing low-threshold and community-led services



Key takeaways

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1

Harm reduction saves lives

- Strong evidence for HIV, HCV and overdose prevention
- Essential public health intervention

2

Harm reduction is essential health care

- WHO recommends NSP, OAMT and naloxone
- Must be embedded within national responses

3

Funding crises threaten continuity

- Service disruptions reverse progress
- Sustainable financing and resilience are critical

4

Integration must protect accessibility

- Low-threshold and community-led services remain essential
- Integration should strengthen — not erase — trusted services

**Low-threshold harm reduction services can also critical be platforms for TB prevention, screening and treatment.*

Thank you

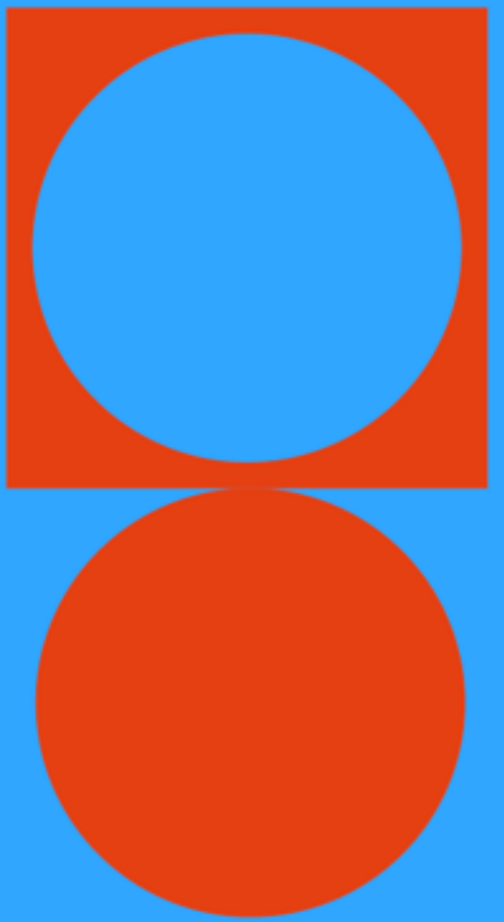
Acknowledgements:

Annette Verster
Virginia Macdonald
Niklas Luhmann
Dzmitry Krupchanka
Anja Busse

World Health Organization

GLOBAL STATE OF HARM REDUCTION & THE FUNDING LANDSCAPE

Catherine Cook, Paulina Cortez, Gaj Gurung
May 2026



HARM REDUCTION INTERNATIONAL

Harm Reduction International- HRI

- An organisation which works to use data and advocacy to promote harm reduction and drug policy reform
- We advocate for an inclusive definition of harm reduction that emphasises non-judgmental, evidence-based health interventions and is grounded in justice.
- Work globally, registered in London UK.

Drugs and health

Drugs and human rights

Funding for harm reduction

Intersectional movement

Conferences and events

HARM REDUCTION INTERNATIONAL

GLOBAL STATE OF HARM REDUCTION

GLOBAL STATE OF HARM REDUCTION- OVERVIEW

112

Countries with explicit supportive references to harm reduction in national policy documents

95

Countries with Opioid Agonist Therapy (OAT)

93

Countries with Needle & Syringe Programmes

19

Countries with Drug Consumption Rooms

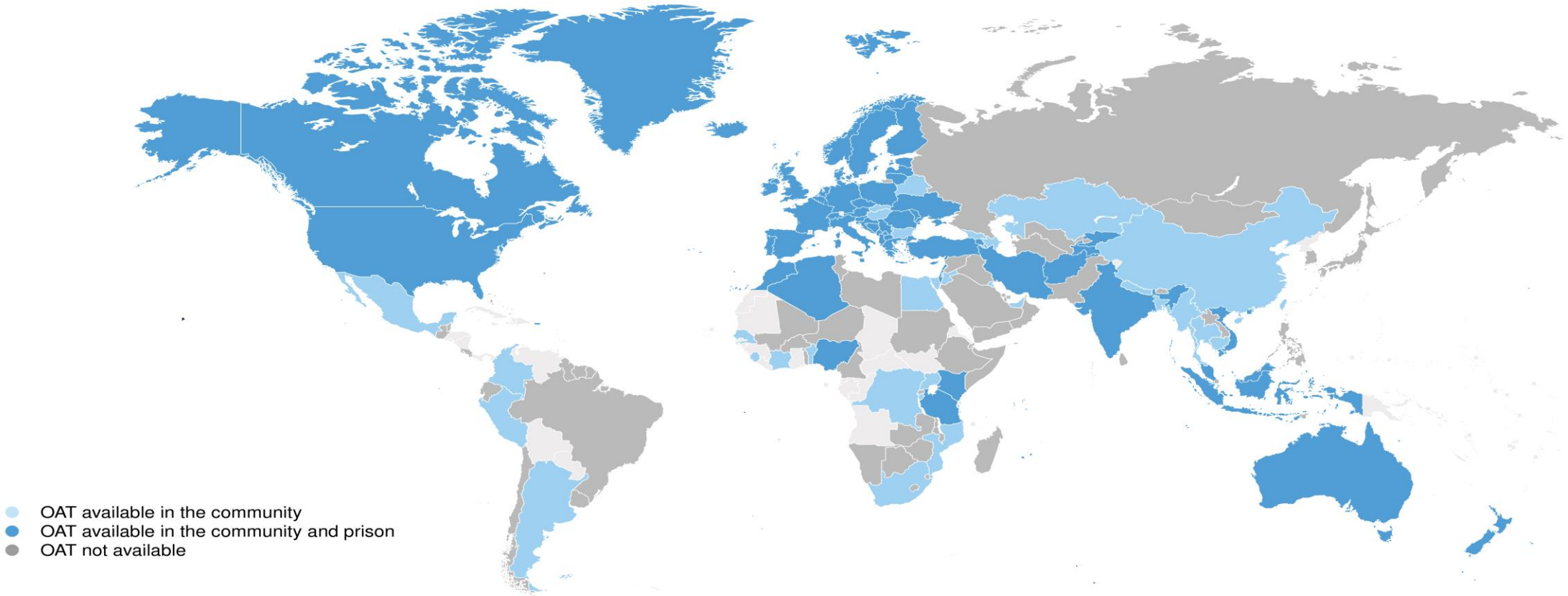
26

Countries with safer smoking equipment

Source: Global State of Harm Reduction 2025-update to key data, hri.global

HARM REDUCTION INTERNATIONAL

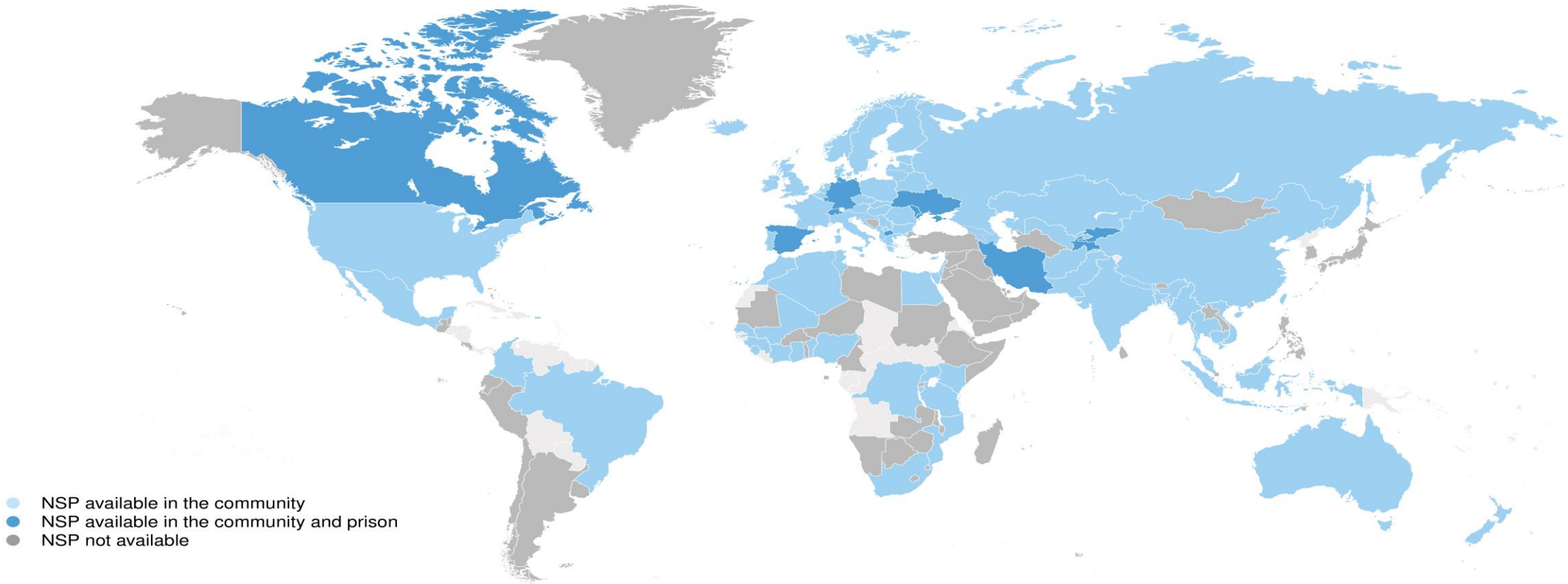
GLOBAL AVAILABILITY OF OPIOID AGONIST THERAPY (OAT) IN THE COMMUNITY AND IN PRISON



HARM REDUCTION INTERNATIONAL

Source: *The Global State of Harm Reduction: 2025 Update to Key Data*

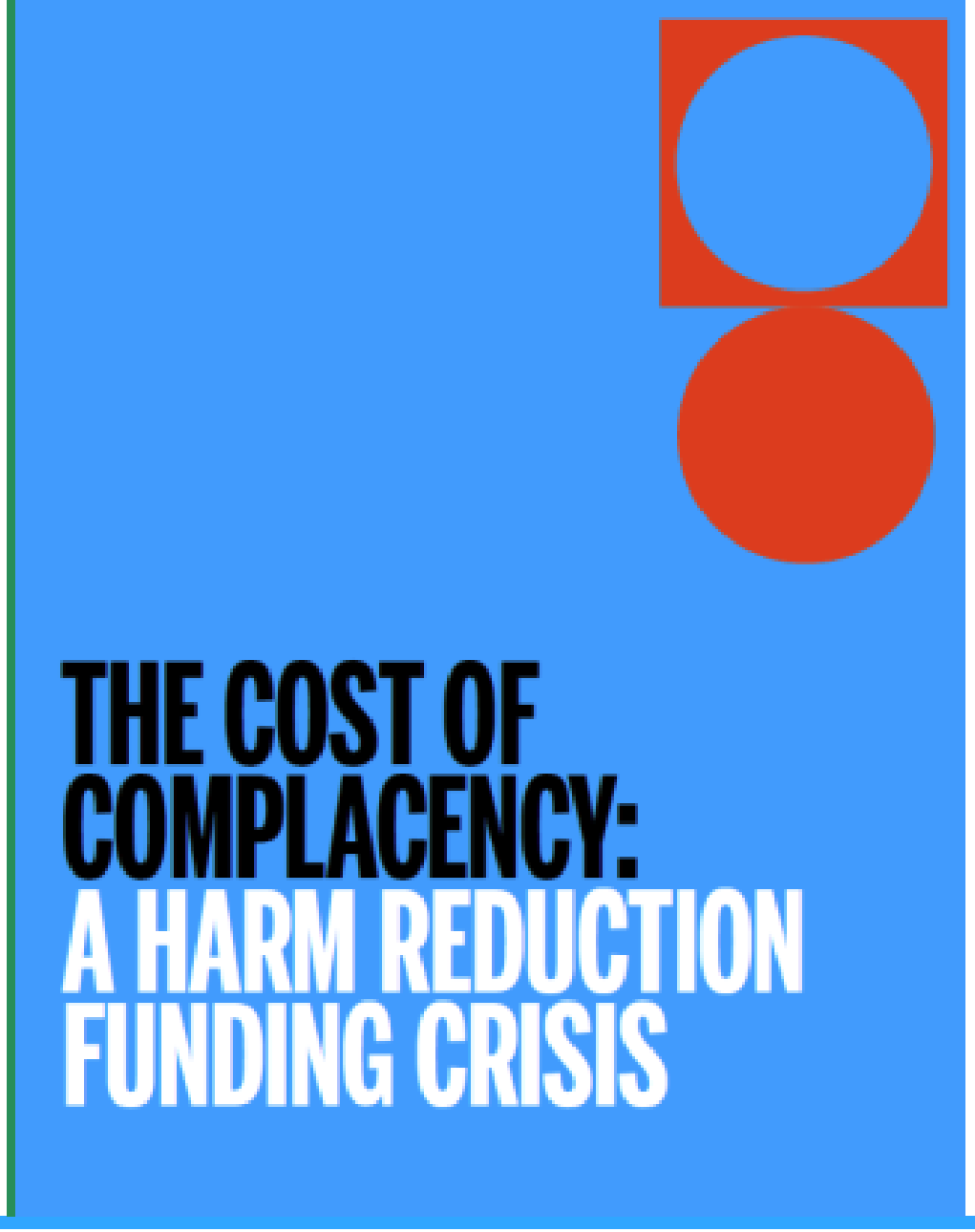
GLOBAL AVAILABILITY OF NEEDLE AND SYRINGE PROGRAMMES (NSPS) IN THE COMMUNITY AND IN PRISON



HARM REDUCTION INTERNATIONAL

Source: *The Global State of Harm Reduction: 2025 Update to Key Data*

Harm Reduction Funding



HARM REDUCTION INTERNATIONAL

HARM REDUCTION FUNDING

94%

FUNDING GAP for harm reduction in LMICs

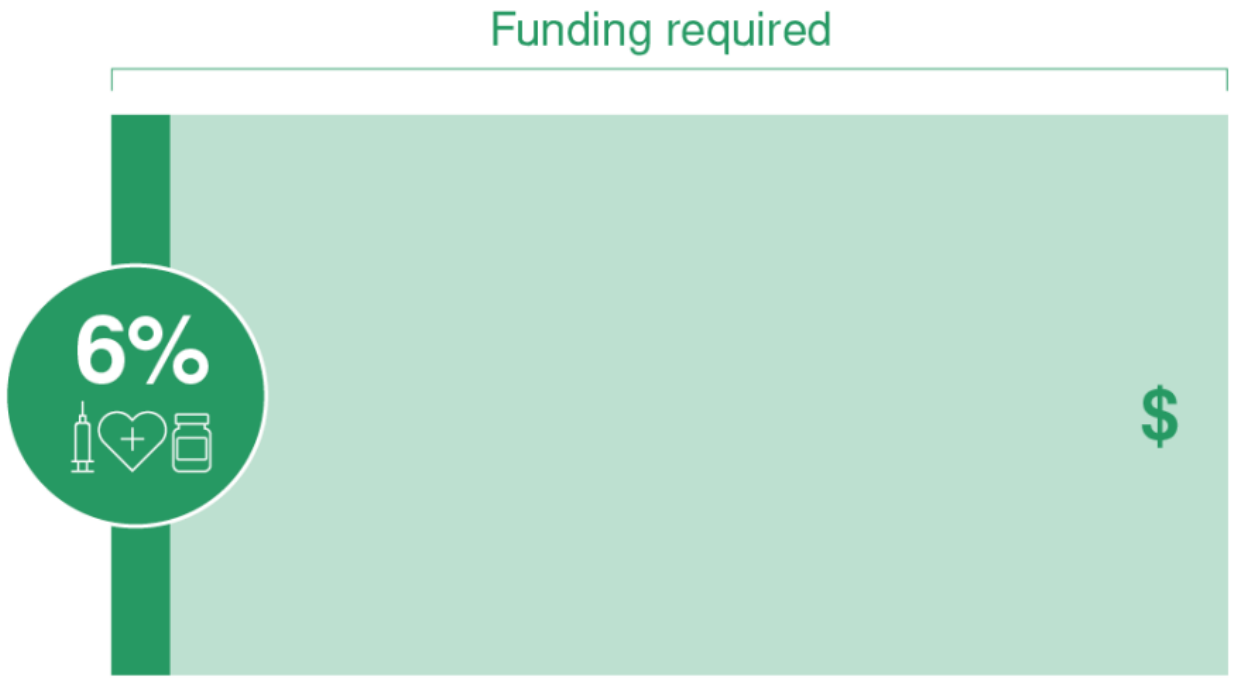
0.7%

OF HIV FUNDING goes towards harm reduction

27

COUNTRIES invest in harm reduction domestically

TOTAL FUNDING FOR HARM REDUCTION IN LOW- AND MIDDLE-INCOME COUNTRIES IS ONLY 6 PERCENT OF WHAT IS NEEDED



HARM REDUCTION INTERNATIONAL

Source: *The Cost of Complacency: A Harm Reduction Funding Crisis*

HARM REDUCTION PUNITIVE FUNDING

While harm reduction funding is in crisis, governments and donors continue to invest vast amounts in punitive drug approaches

$151 MILLION

Total harm reduction spending in LMICs (HRI 2024)

$100 BILLION

Global drug law enforcement expenditure per year

$2.7 BILLION

Needed for harm reduction in LMICs annually by 2025 (UNAIDS estimation)

GLOBAL FUNDING CUTS- CONTEXT

- In January 2025, the U.S. government abruptly halted bilateral and multilateral aid.
- The U.S. had been the **second-largest harm reduction donor** (after the Global Fund) and the **largest contributor to the Global Fund portfolio.**
- Global Fund grant allocations were reprioritised, removing planned harm reduction scale-up and supportive programming for *Grant Cycle 7*.
- The Global Fund mobilised USD 12.6 billion (USD 10.78 billion for country allocation) in its 8th replenishement; as compared to USD 15.7 billion in 7th replenishment (USD 13.2 billion for country allocations)
- Impacts on wider health infrastructure, communities and civil society and UN agencies
- **This is not merely a funding crisis. It is a human rights crisis.**

GLOBAL FUNDING CUTS- LARGER IMPACT

Funding reduction

USD 10 million funding reduction in harm reduction post Global Fund GC7 re-prioritsation (without Ukraine)

Source: https://www.dataetc.org/projects/reprioritization/?lang=EN

Cancelled

PEPFAR harm reduction funding which was set to double in 2024

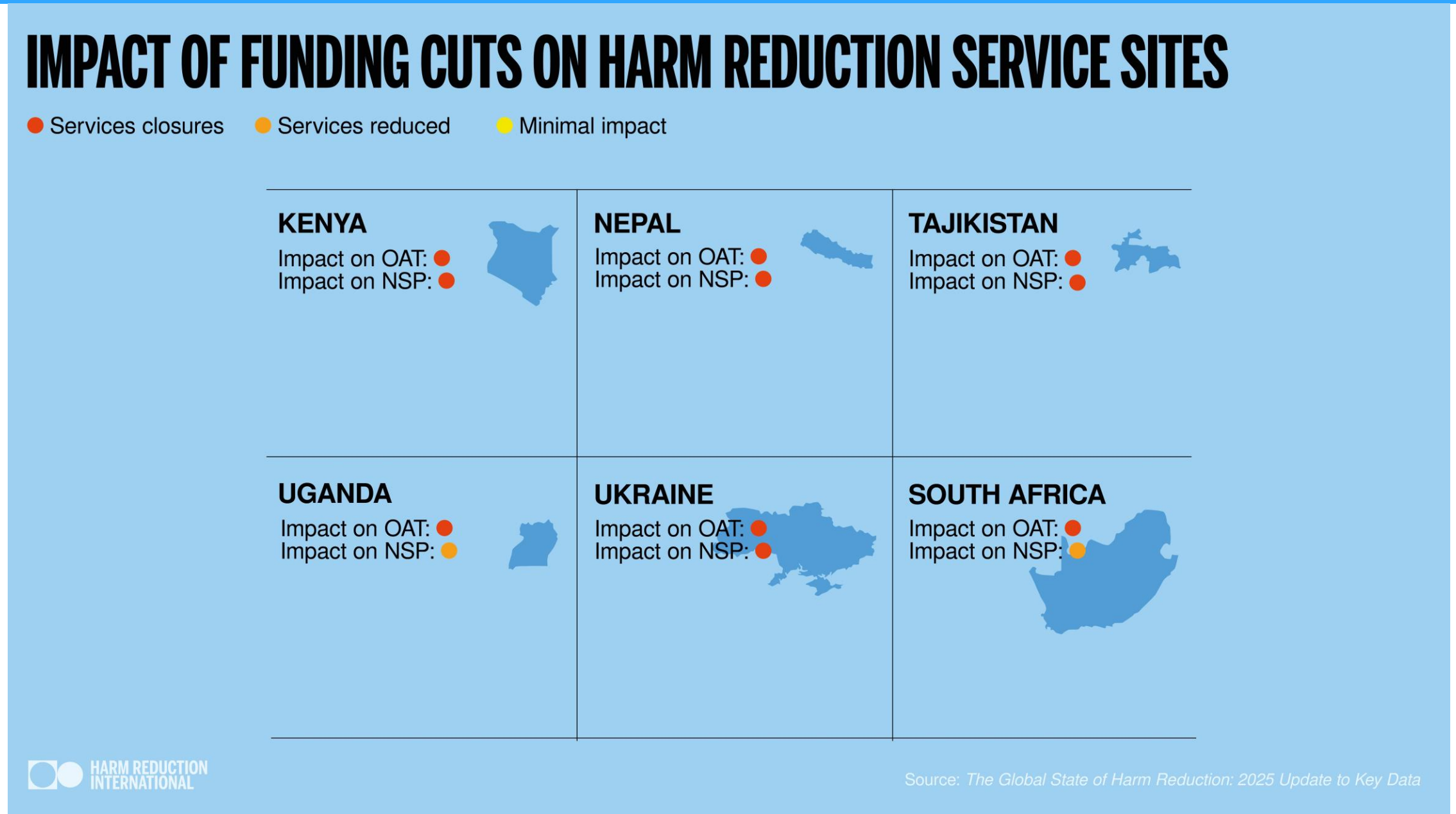
Source: UNAIDS 2024

New HIV infections

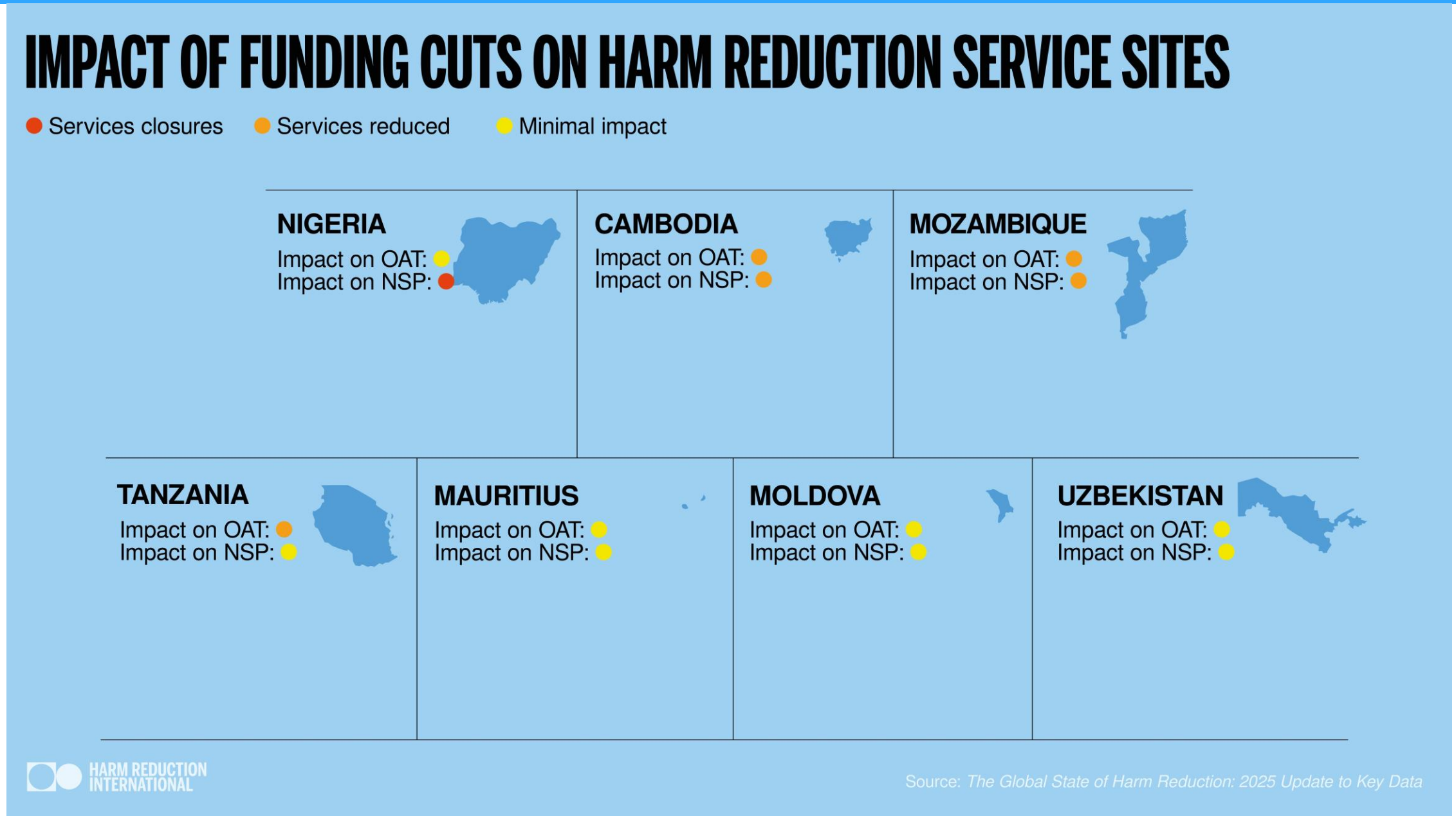
9467 new HIV infections and 13,202 new HCV infections among people who inject in one year funding disruptions

Source: https://doi.org/10.1016/j.drugpo.2026.105290

GLOBAL FUNDING CUTS- IMPACT IN SERVICES



GLOBAL FUNDING CUTS- IMPACT IN SERVICES



Moving ahead

- Harm reduction is essential to ending AIDS as a public health threat by 2030.
  - People who inject drugs are the second highest contributor to overall new HIV infections
  - Has the highest incidence rate ratios of acquiring HIV

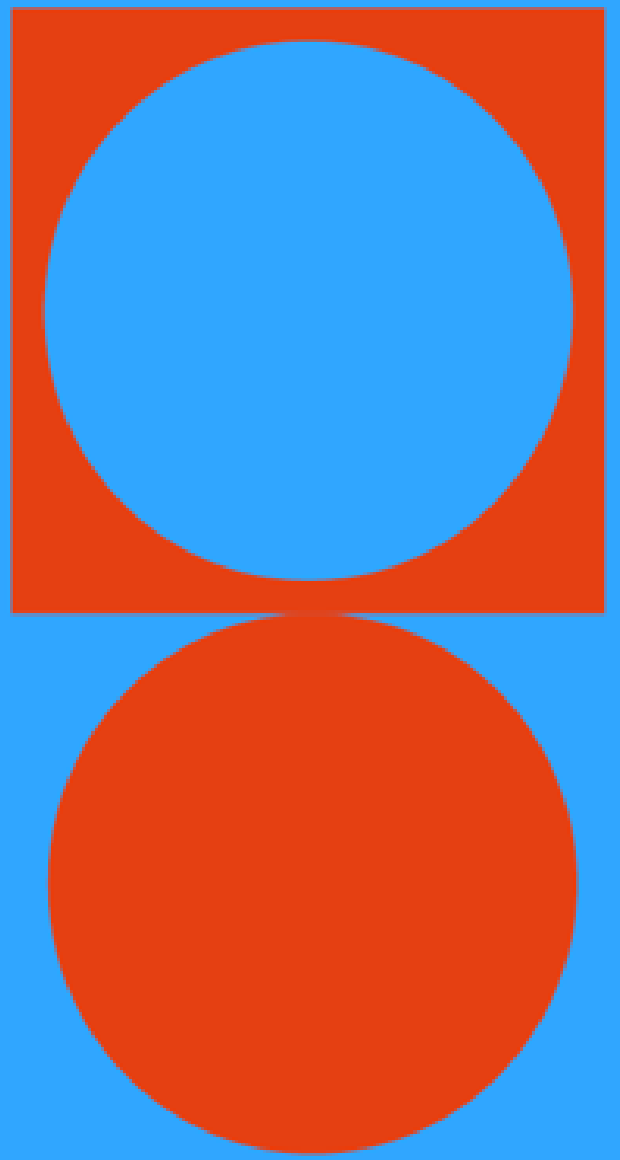
- Harm reduction is cost-effective and evidence based; and has broader benefits beyond HIV prevention.

- Domestic funding is key to sustain harm reduction

- Integration of harm reduction into Universal Health Coverage such as primary health care, health insurance- through nuanced analysis (otherwise equity risks)

- Social contracting is required to strengthen community systems- key to health system

THANK YOU



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HARM REDUCTION INTERNATIONAL

Country implementation snapshots: How countries are embedding harm reduction into national systems

Moderator: Dr Stela Bivol, WHO Europe

Dr Barbara Mambo, HIV Prevention Lead, National HIV Clinical Support Center NASCOP, Ministry of Health, Kenya

Dr Ibtissam Khoudari, Head of AIDS and STI Programme, Ministry of Health, Morocco

Dr Filipa Alves da Costa, Advisor, Ministry of Health, Portugal

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Accelerating Access to Opioid Agonist Maintenance Therapy in Kenya

Dr Barbara Mambo | Lead HIV Prevention, NASCOP MOH Kenya

Kenya experience in system-led scale-up

NASCOP

Country context and key challenges

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Why OAMT matters in Kenya

- **Estimated 30,641 people who inject drugs nationally, concentrated in urban and coastal areas.**
- **HIV prevalence among people who inject drugs is 8.8% overall, but 24.0% among women who inject drugs.**
- **Heroin remains the dominant injected drug; 28.3% still report needle sharing.**
- **The core challenge is scaling access, retention, and sustainability.**

High burden, uneven vulnerability

NASCOP

Kenya's harm reduction model and services

REPUBLIC OF KENYA

MINISTRY OF HEALTH

OAMT is delivered as part of a wider public health package

- **Methadone and buprenorphine are used for maintenance treatment under national guidance.**
- **Services are linked to HIV testing and treatment, tuberculosis care, hepatitis services, psychosocial support, condoms, outreach, and overdose prevention.**
- **Delivery models include fixed clinics, community-linked services, prison-based models, and mobile dispensing.**

Treatment + prevention + support

NASCOP

Embedding harm reduction into national systems

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Policy, governance, and community role

- National guidelines provide the policy and operational framework for medically assisted therapy.
- The approach is rights-based, evidence-based, and community-informed.
- National leadership provides policy and oversight; counties manage much of routine service delivery.
- Peer-led and civil society organizations support mobilisation, follow-up, counselling, and trust.

Policy-backed and community-linked

NASCOP

Embedding harm reduction into national systems

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Financing, sustainability, and health service integration

- **By December 2025, Kenya had 15 MAT clinics in 7 counties, with 10,605 clients ever enrolled and 4,638 currently on treatment.**
- **Day-to-day clinic management is increasingly embedded within county systems.**
- **Sustainability requires governance, workforce, service continuity, commodities, data systems, and financing.**

From partner support to system ownership

NASCOP

Results, lessons learned and remaining challenges

REPUBLIC OF KENYA
MINISTRY OF HEALTH

What Kenya's experience shows

- **23,298 people reached with harm reduction services alongside OAMT scale-up.**
- **Among people who inject drugs living with HIV: 95.4% know their status, 91.8% are on treatment, and 89.0% are virally suppressed.**
- **OAMT works best when linked to HIV, hepatitis, tuberculosis, psychosocial, and community services.**
- **Remaining priorities: retention, overdose response, commodity security, financing, and community-led models.**

Scale requires sustained financing

ROYAUME DU MAROC

Ministère de la Santé
et de la Protection Sociale

DIRECTION DE L'EPIDEMIOLOGIE
ET DE LUTTE CONTRE LES MALADIES

المملكة المغربية
ⵜⴰⴳⵍⴷⵉⵜ ⵏⵍⵎⵖⵔⵉⴱ
وزارة الصحة والحماية الاجتماعية
ⵜⴰⵎⴰⵡⴰⵙⵜ ⵏ ⵜⵣⵎⵔⵜ ⴷ ⵜⵣⵔⴼⵜ ⵜⴰⵏⴰⵎⵓⵔⵜ
مديرية علم الأوبئة ومحاربة الأمراض
ⵜⴰⵎⴰⵡⴰⵙⵜ ⵏ ⵜⵙⵏⵙⵓⵜ ⴷ ⵓⵙⵓⵔⵙ ⵅ ⵜⵎⵣⵉⴰ

From evidence to essential services: embedding harm reduction in national health systems

Country Focus: Morocco

Ibtissam KHOUDRI, MD, MPH, PhD

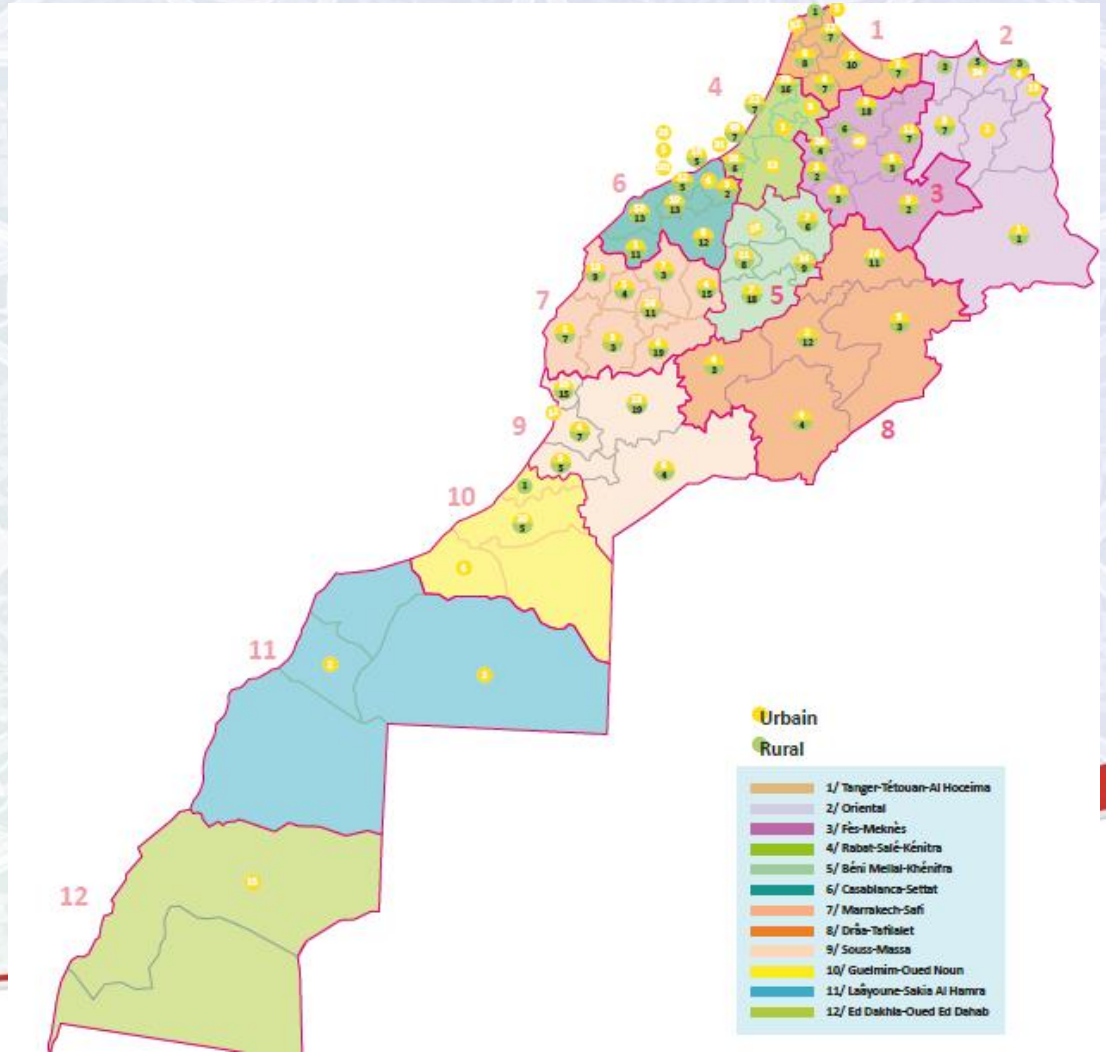
National HIV, STI and Viral Hepatitis Program Manager

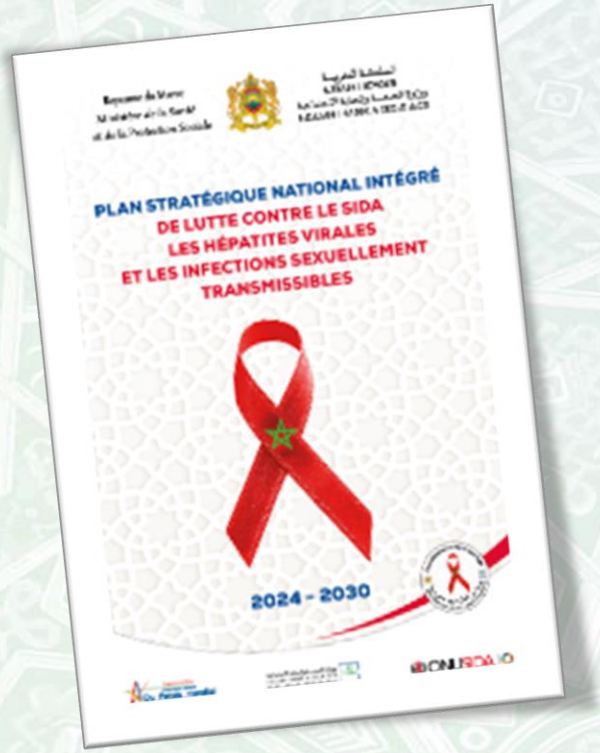
MOH/ Morocco

May 12th, 2026

Kingdom of Morocco

- 35 millions habitants
- 12 administrative regions

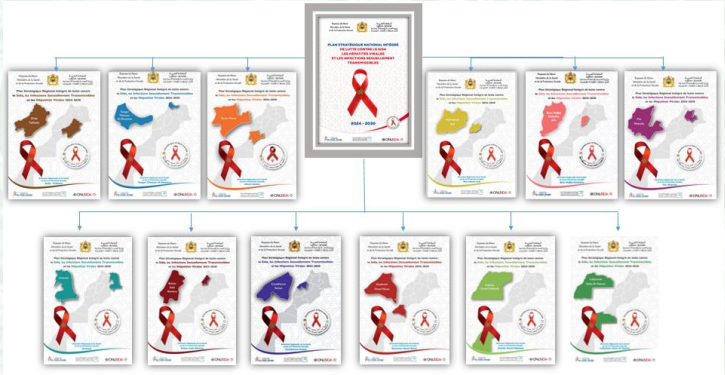




Integrated National Strategic Plan for HIV, STIs and Viral Hepatitis 2024–2030

VISION

A Morocco free of AIDS, viral hepatitis, and STIs by 2030, with the involvement and active mobilization of all national and international stakeholders.



GOAL

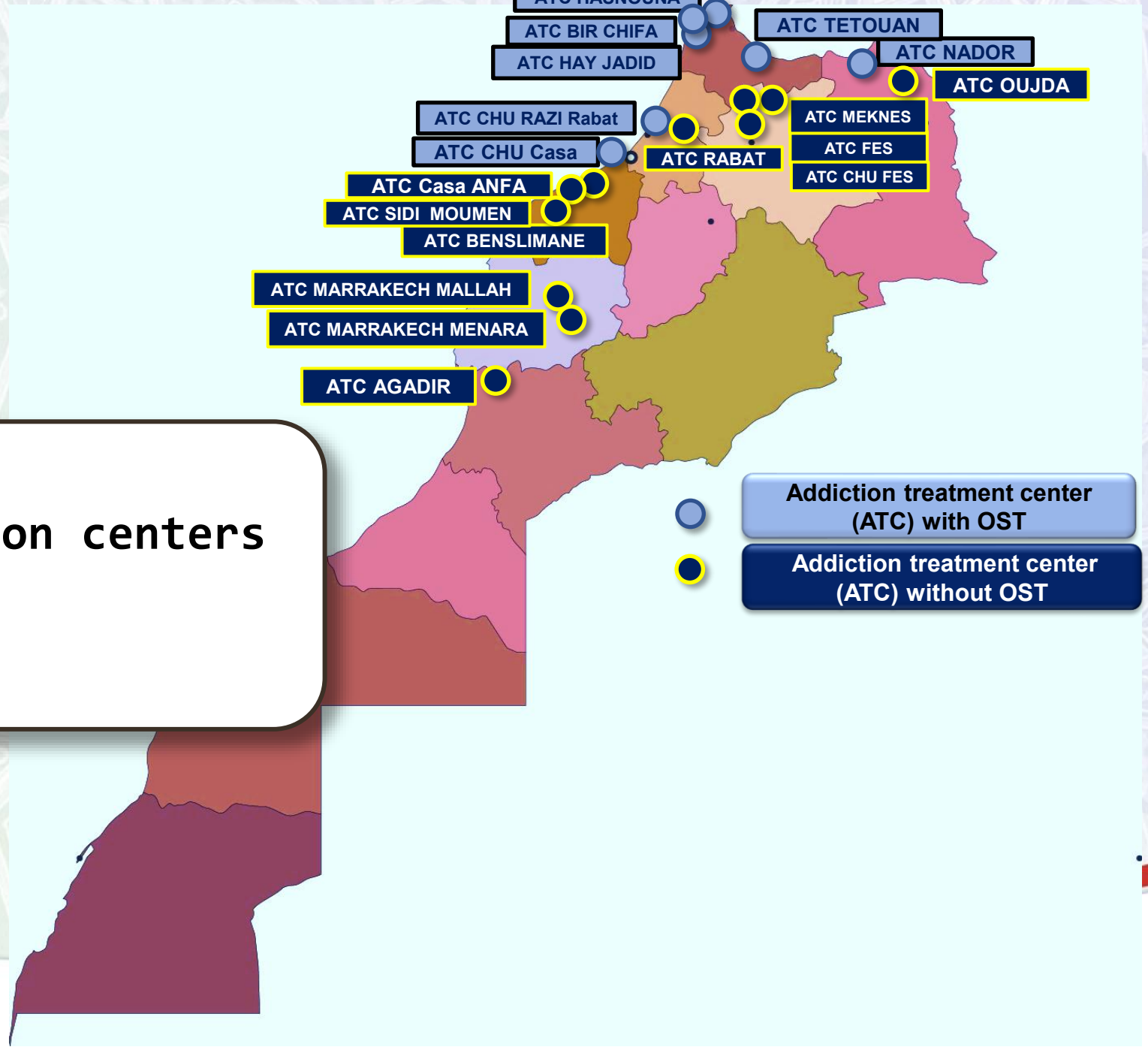
Eliminate the epidemics of AIDS, viral hepatitis, and STIs as public health threats.

Epidemiological situation

Estimated number of people who inject drugs (PWID): 1 700

Prevalence	Prevalence among PWID*	General population
HIV	5,3 %	0.08%
HCV	62,8 %	0.5%

Réf. : Enquête bio-comportemauprès des personnes qui s'injectent des drogues (MSPS, 2023)



27 Harm Reduction centers

8 PROVIDE OST

Typical model of a **Harm Reduction** center:

- **Status:**
  Part of the primary health care level facilities .

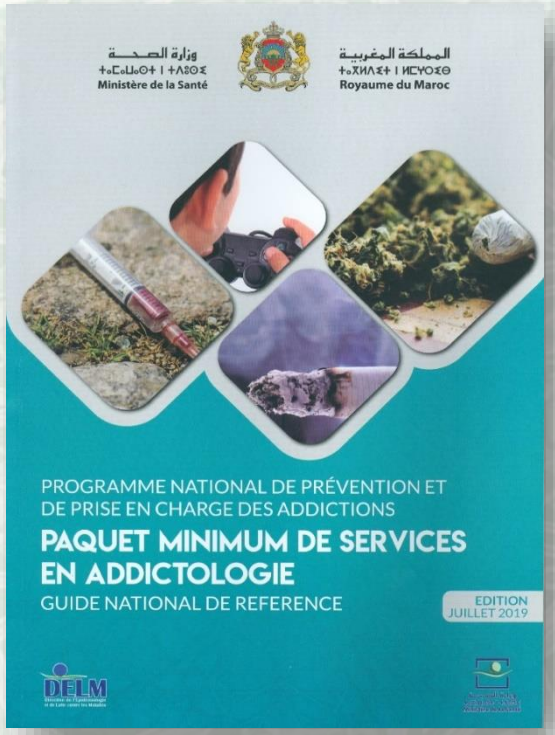
- **Organisation:**

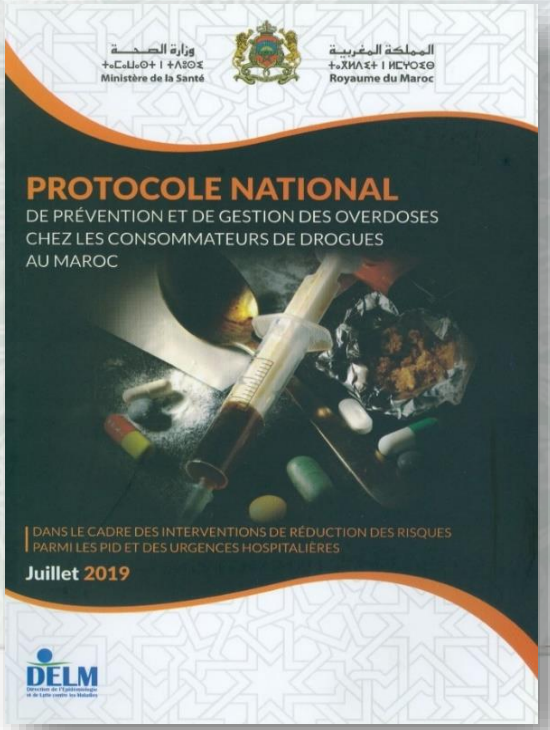
Medical unit: 1 addiction specialist physician; 1 part-time psychiatrist; 1 social worker; 4 nurses; 1 psychomotor therapist; 1 psychologist.

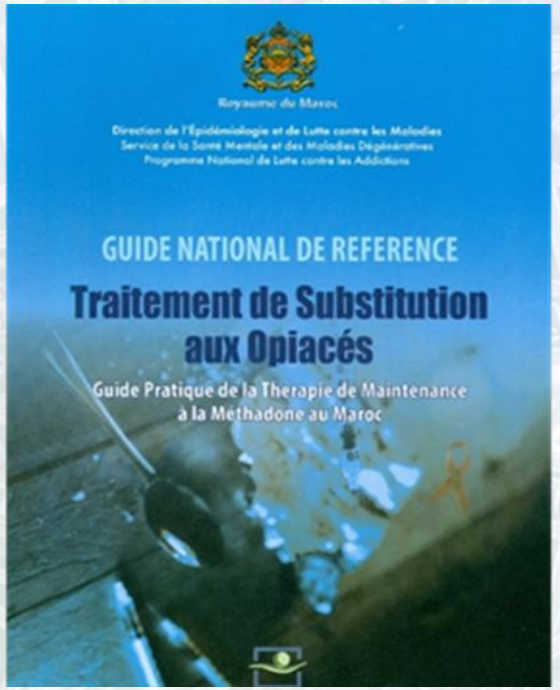
Social unit: basic services, social activities, occupational activities, peer support, legal counseling, social support, etc.

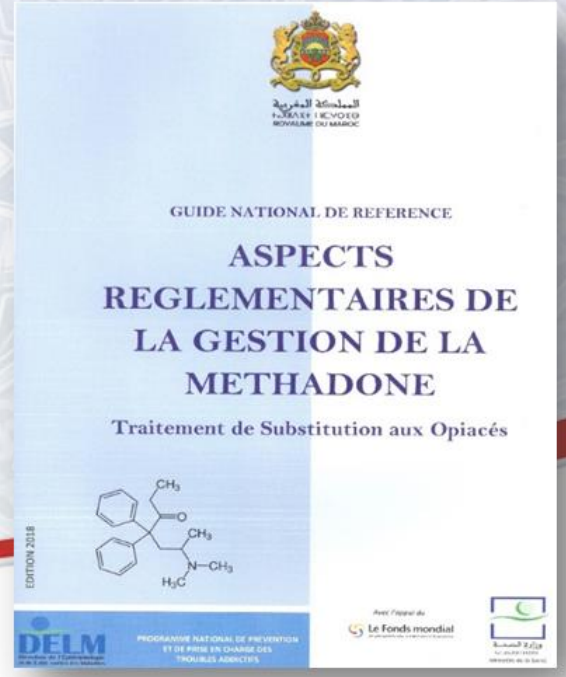
Mobile unit (outreach).

Normative frameworks







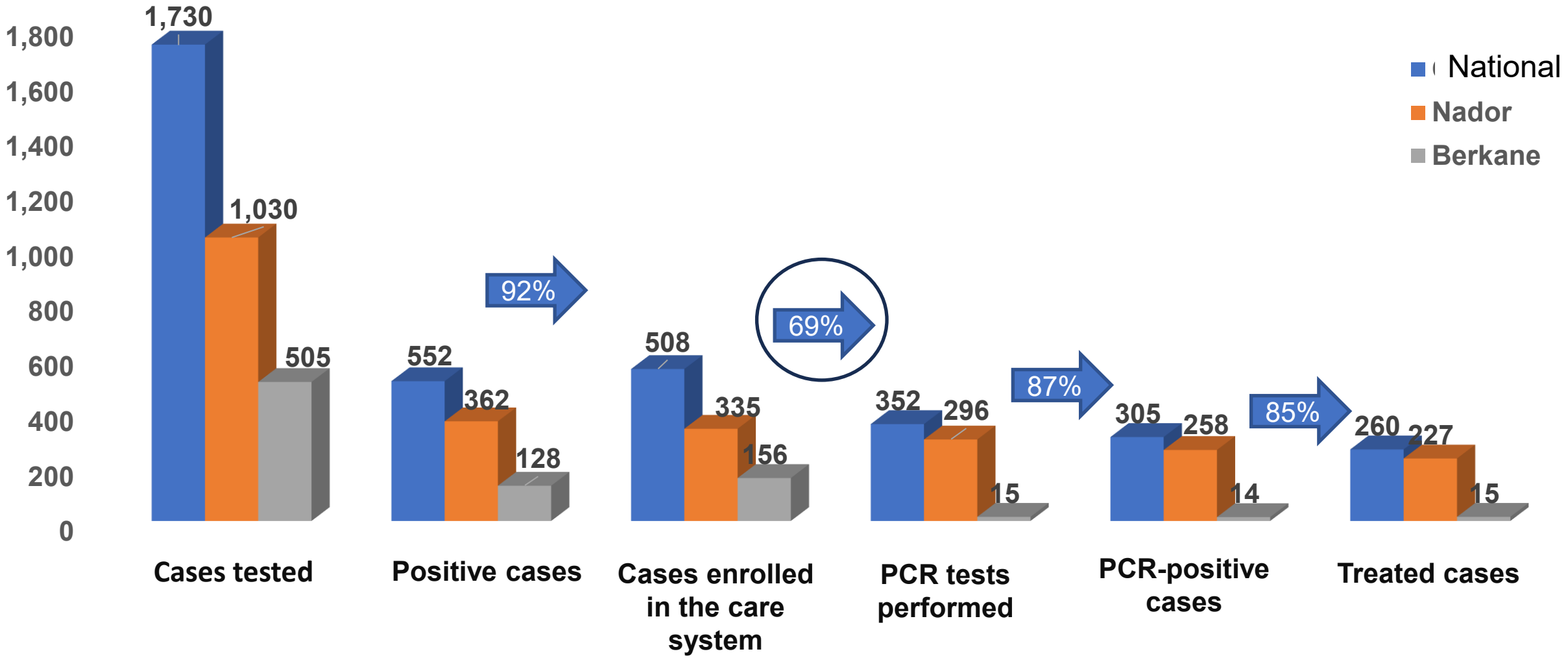


Achievements

- Expansion of addiction treatment centers to areas where needs have been identified as priority areas.
- Currently, among the 27 addiction treatment centers, 8 provide OST.
- PWIDs under OST : nearly **1 500**
- **88%** of people who inject drugs received infection prevention services (in 2025)
- **86%** retention rate under OST for more than 6 months (in 2025)
- **83%** of people who inject drugs received an HIV test and know their results (in 2025)

HCV CARE CASCADE AMONG PWIDS

Juillet 2022 – Janvier 2026



HCV care cascade among people who inject drugs (PWID) in the Oriental region (Nador and Berkane)

HCV micro-élimination among pwids

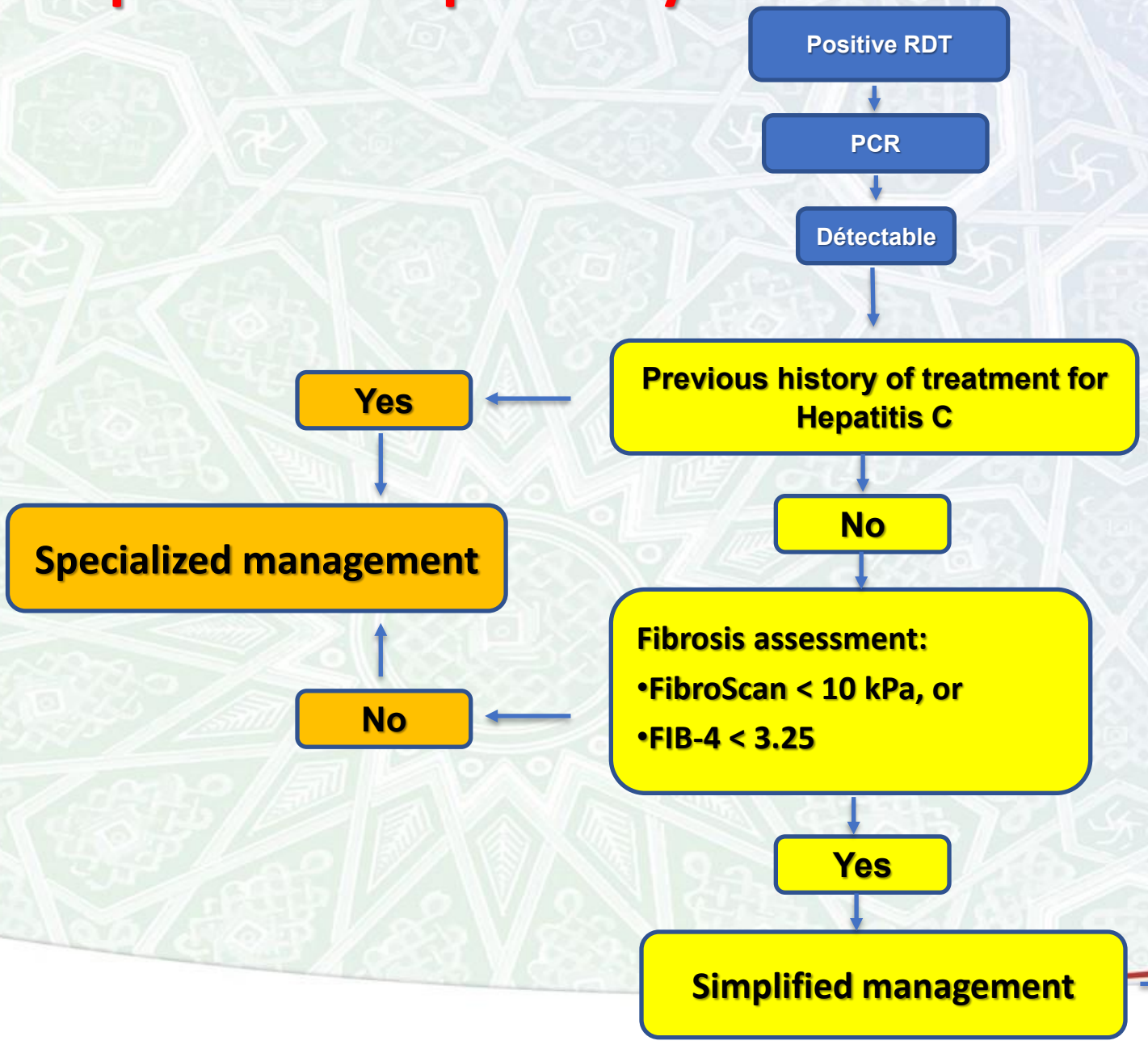
Who is the simplified care pathway for?

- **Absence of Hepatitis B and/or HIV co-infection**
- **No severe renal impairment (eGFR < 30 mL/min/1.73 m²)**
- **No severe liver disease**
- **No previous Hepatitis C antiviral treatment**

3 Objectives

- ✓ Screen at least 95% of people who inject drugs (PWID).
- ✓ Confirm the diagnosis by PCR in all those who test positive (at least 95%).
- ✓ Treat at least 95% of viremic patients.

Simplified care pathway for PWIDs HCV+



- ✓ A simplified pre-treatment work-up may be requested, including **complete blood count**, **transaminases, urea,** and **creatinine**.
- ✓ PCR testing may be performed using **GeneXpert directly at the addiction treatment center** to improve retention in care.
- ✓ **Treatment initiation** should be carried out by a **non-gastroenterologist physician or an addiction specialist within the addiction treatment center**.
- ✓ **Direct-acting antivirals (DAAs) may be dispensed monthly by a community worker, or according to the schedule of outreach visits,** to facilitate adherence
- ✓ Initiation of Methadone is recommended before starting treatment for Hepatitis C

Risk of HCV reinfection

- Risk of 5.3 to 7.7 per 100 person-years in cases with ongoing intravenous drug use.
- Treatment to prevent reinfection: Reduces the incidence of new infections by 50%. prévenir la réinfection
- OST: Reduces the risk of new HCV infection by 50%.
- Concomitant use of needle and syringe exchange programs: Reduces reinfection by 74%.
- **Given this risk: Annual PCR testing is recommended**.

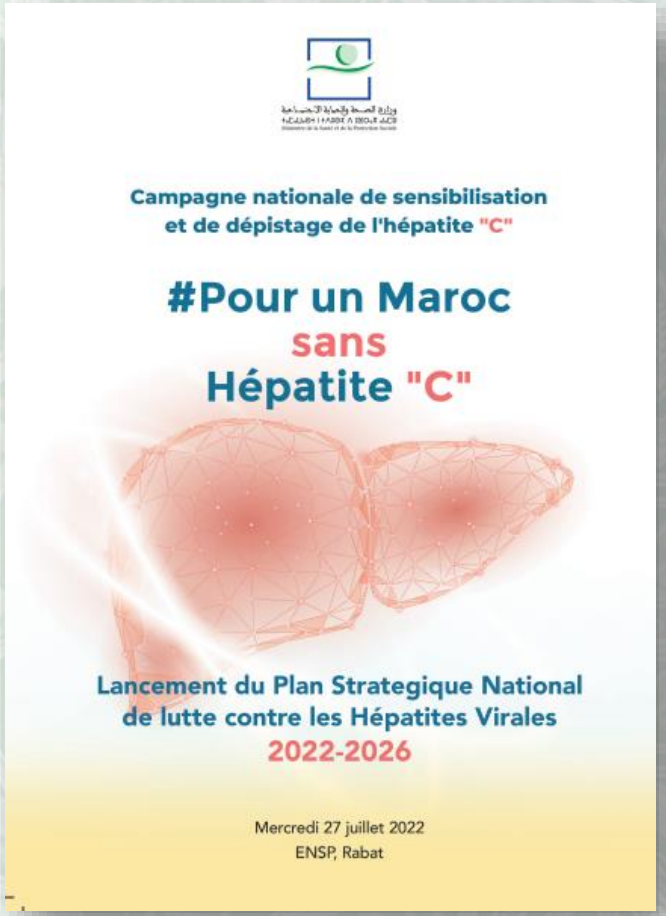
BEST PRACTICES, CHALLENGES AND THE WAY FORWARD

Best practices

- Integrated HIV, HCV and Harm reduction services
- Pilot project underway for HCV micro-elimination and simplified patient pathway
- Complementarity between civil society and the institutional sector
- Digitalized and unified information system

Remaining challenges and the way forward

- Extension des machines Genexpert dans tous les centres d'addictologie offrant la TSO
- Intégration of HBV and TB services
- Involvement of private sector and extension of medical health coverage



Ensemble pour un Maroc sans SIDA

Thank you !

Merci

شكرا

Country implementation snapshots

How Portugal has embedded harm reduction into national systems

Filipa Alves da Costa, Advisor to the Minister of Health

REPÚBLICA PORTUGUESA
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Historical context

- Portugal before the year 2000
- High prevalence of heroin use and injecting drug use
- High number of HIV, HCV, TB infections and deaths
- Opioid agonist programmes (experimental programme with methadone 1977, Programmes with increased coverage 1997);
- Needle and Syringe Exchange Program initiated in Pharmacies 1993

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National Strategy against drugs, 1999

- **Main Recommendations:**
  - Study measures for better grading of drug trafficking sanctions
  - Decriminalize private consumption, as well as possession or acquisition for that consumption
  - Anticipate diversion to treatment as an alternative to incarceration

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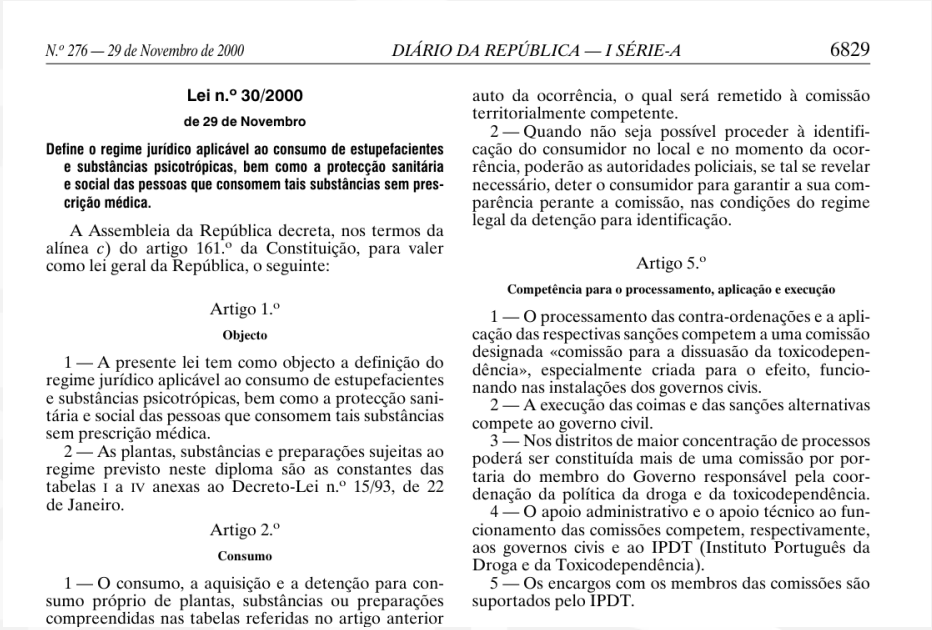
https://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/48/ENcomissao.pdf

Law 30/2000: Portuguese law that decriminalized the use, acquisition, and possession of drugs for personal use in Portugal, converting these situations from criminal offences into administrative offences. The law also established health and social protection measures for PUD.



N.º 276 — 29 de Novembro de 2000 DIÁRIO DA REPÚBLICA — I SÉRIE-A 6829

Lei n.º 30/2000

de 29 de Novembro

Define o regime jurídico aplicável ao consumo de estupefacientes e substâncias psicotrópicas, bem como a protecção sanitária e social das pessoas que consomem tais substâncias sem prescrição médica.

A Assembleia da República decreta, nos termos da alínea *c*) do artigo 161.º da Constituição, para valer como lei geral da República, o seguinte:

Artigo 1.º

Objecto

1 — A presente lei tem como objecto a definição do regime jurídico aplicável ao consumo de estupefacientes e substâncias psicotrópicas, bem como a protecção sanitária e social das pessoas que consomem tais substâncias sem prescrição médica.

2 — As plantas, substâncias e preparações sujeitas ao regime previsto neste diploma são as constantes das tabelas I a IV anexas ao Decreto-Lei n.º 15/93, de 22 de Janeiro.

Artigo 2.º

Consumo

1 — O consumo, a aquisição e a detenção para consumo próprio de plantas, substâncias ou preparações compreendidas nas tabelas referidas no artigo anterior

auto da ocorrência, o qual será remetido à comissão territorialmente competente.

2 — Quando não seja possível proceder à identificação do consumidor no local e no momento da ocorrência, poderão as autoridades policiais, se tal se revelar necessário, deter o consumidor para garantir a sua comparência perante a comissão, nas condições do regime legal da detenção para identificação.

Artigo 5.º

Competência para o processamento, aplicação e execução

1 — O processamento das contra-ordenações e a aplicação das respectivas sanções competem a uma comissão designada «comissão para a dissuasão da toxicodependência», especialmente criada para o efeito, funcionando nas instalações dos governos civis.

2 — A execução das coimas e das sanções alternativas compete ao governo civil.

3 — Nos distritos de maior concentração de processos poderá ser constituída mais de uma comissão por portaria do membro do Governo responsável pela coordenação da política da droga e da toxicodependência.

4 — O apoio administrativo e o apoio técnico ao funcionamento das comissões competem, respectivamente, aos governos civis e ao IPDT (Instituto Português da Droga e da Toxicodependência).

5 — Os encargos com os membros das comissões são suportados pelo IPDT.

Law-Decree 183/2001 - Prevention and Harm Reduction Policies

Outreach teams
Mobile units
Low-threshold opioid substitution programmes
Drop-in services
Supervised consumption rooms
Needle and syringe programmes
Drug testing
Referral pathways and linkage to care

Publicly funded harm reduction responses implemented through the Operational Plan for Integrated Responses

The existence of **screening and referral** according to the identified needs is an **essential condition for the financing** of Risk Reduction and Harm Minimization projects.

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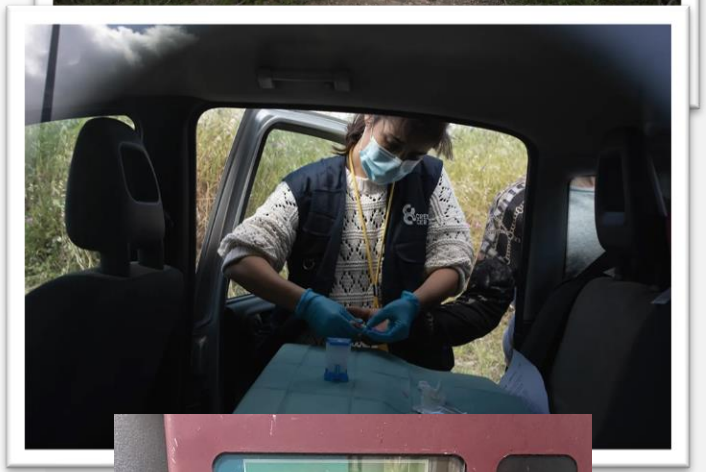
Implementation

The report *HIV infection in Portugal - 2024*, by DGS/INSA, identifies the NSEP as an RRMD program that has contributed significantly to reducing the proportion of new cases of HIV infection in people who inject drugs (PUD).

In 2024, a total of 918,328 syringes were distributed (87.1% outreach teams, 11.9% pharmacies, 0.9% in Primary care units)



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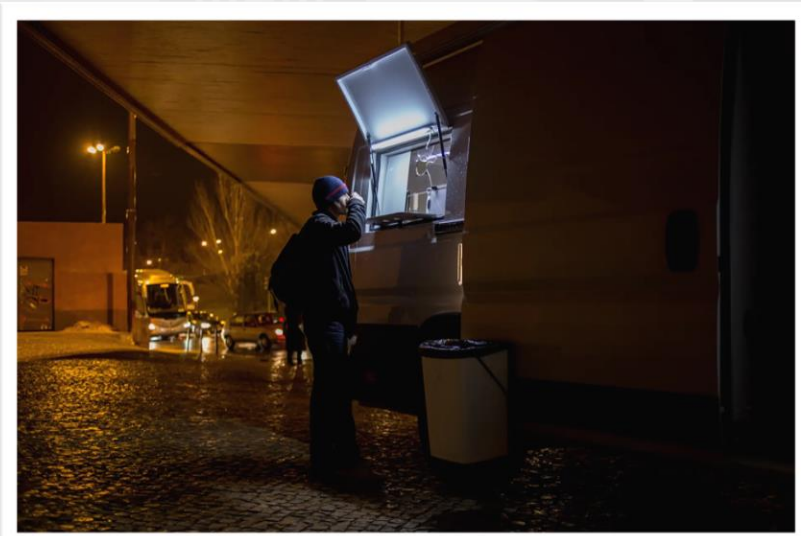
Low threshold treatment with opioid agonists

- Flexible entry procedures (free, no documents, no abstinence
- Accessible through mobile units
- Dose established by medical Rx
- Screening for TB, HIV, viral hepatitis and STI
- Referral, follow-up, medicines storing
- Social Support
- Peer support
- Collaboration with hospitals and health care centers



High threshold OAT

- Pharmacies and healthcare centers
- DOT
- Abstinence and testing

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Drug consumption rooms

- Consumption-related risk reduction (smoked, injected)
- Direct support in overdose
- Facilitate access to social/health services
- Screening, referral, access to treatment (infectious, addictions and others)

- Fixed space or in public spaces
- Information about drug quality

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Broader framework of combined prevention

- Distribution of **preventive material**, condoms and lubricants
- Screening and referral to care facilitating **ART access**
- Access to **PrEP and PEP**

- Integration of harm reduction strategies in responses to HIV, viral hepatitis, tuberculosis and other STIs
- Strengthened through the Portuguese participation in the international initiative **Fast-Track Cities** - involves several municipalities and local structures, DGS, INSA, SNS, ICAD, hospitals, CSOs and community projects
- By 2018, 10 Portuguese municipalities adhered to the Paris Declaration — Lisbon, Porto, Cascais, Almada, Amadora, Loures, Oeiras, Odivelas, Portimão and Sintra — making Portugal the first "Fast Track Country". – In 2025, 12 cities

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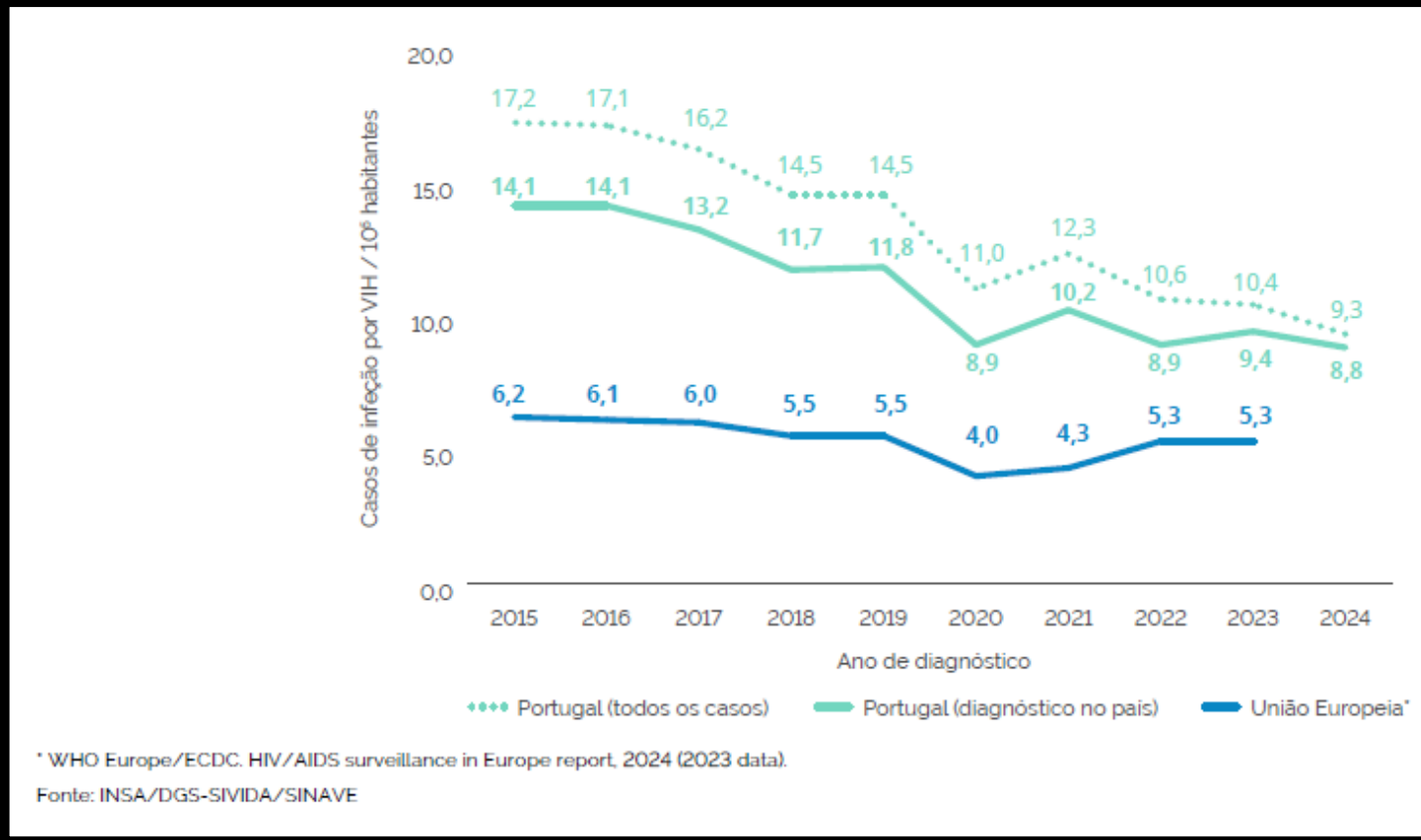
In 2024, 44 harm reduction projects were ongoing in mainland Portugal



* WHO Europe/ECDC. HIV/AIDS surveillance in Europe report, 2024 (2023 data).

Fonte: INSA/DGS-SIVIDA/SINAVE

35% reduction in the number of new cases of HIV infection

43% reduction in the number of new cases of AIDS

In 2023, 49,699 people were living with HIV in Portugal, of which 94.2% had been diagnosed

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[Infeção por VIH em Portugal – 2025]

Conclusion:

In Portugal, harm reduction is embedded in national public policies on addictive behaviours and dependencies, with a strong public health focus on the prevention of HIV, viral hepatitis, tuberculosis and other sexually transmitted infections among people who use drugs, particularly people who inject drugs.

Portugal's experience shows that harm reduction is not a parallel response, but an integrated component of public health, social care and community-based strategies, involving ICAD, the National Health Service, municipalities and civil society organisations.

REPÚBLICA
PORTUGUESA

SAÚDE

Interactive partner panel discussion: Overcoming barriers and sustaining services

Moderator: Dr Niklas Luhmann, Regional Reference Physician for Sexual Health, HIV, Viral Hepatitis, and Other STIs, Île-de-France Regional Health Agency

Ahmed Said, Regional Coordinator, AfricaNPUD

Gorica Popovic, Associate Programme Officer, Laboratory and Scientific Services Branch, United Nations Office on Drugs and Crime (UNODC)

Maria-Goretti Loglo, Africa Consultant for International Drug Policy Consortium (IDPC)

Matteo Cassolato, Technical Advisor, Key Populations, The Global Fund

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8 September

Ensuring equitable access for key populations sensitive services

6 October

Building sustainable social protection for multiple health needs: lessons from the TB response

6 November 2026

Strategies for sustaining person-centred and community-led interventions for vulnerable populations

Thank You! Merci! Obrigado!

We extend our sincere and heartfelt thanks to all the speakers who generously contributed their expertise and time, as well as to everyone involved in coordinating and preparing this webinar. Your dedication is what makes these sessions so impactful for health professionals around the world.

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Partners & Collaborators

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