

UNAIDS STRATEGY DEVELOPMENT

UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Country: **Global**

Organizer: **Harm Reduction International**

Date: **30 July 2020**

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UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Please use the template to organize your feedback from the session. Please keep responses succinct and as clear as possible to ensure our synthesis is a reflection of the focus groups hosted.

You can enter your report directly into a form on SurveyMonkey:

<https://www.surveymonkey.com/r/3HC9Q6M>

If you are not able to enter it on line you can send us a copy via e-mail strategyteam@unaid.org

Would you accept for UNAIDS to make your report publicly available: **Yes** / No

SECTION 1: Information about the focus group (to be completed by host of Focus Group)

Organization leading discussion: **Harm Reduction International**

Date of discussion: **30 July 2020**

Theme to be discussed: **Achieving sustainable funding for harm reduction**

Participants (types of organizations participating): **Please see participants list attached**

Country, regional or global focus: **Global**

Introducing the theme

Please enter the main characteristics of the theme being explored in 5 sentences (please share the presentation if possible by email)

- Funding for harm reduction is in crisis. Only USD 188 million was allocated to harm reduction in low-and-middle income countries in 2016 (at the last count). This figure did not change since 2007. International donors are the biggest funders yet they are withdrawing from middle-income countries where majority of people who inject drugs live. Only few governments stepped in to continue the funding. In many countries however, funding for harm reduction has been discontinued and people who inject drugs were left behind.
- This is due to a lack of political will and commitment from national governments driven by stigma, discrimination and criminalisation. Many governments and some UN agencies still invest more funding in ineffective punitive responses to drugs instead of life saving harm reduction services. Globally, 50 times more is invested in drug law enforcement than harm reduction. Which in turn reinforces status quo where stigma, discrimination and criminalisation are driving forces behind lack of funding for harm reduction services.

- Prevalent stigma, discrimination and criminalisation also drives the paradox of data. Many governments deny existence of key populations, including people who inject drugs and therefore do not collect data or keep outdated and incorrect data. This in return prevents them from starting or scaling up harm reduction services and allows to report that they are reaching targets set for people who inject drugs based on incorrect data. This data (or no data) is shared with UNAIDS as official country data. Global Fund, the major funder of harm reduction, relies on UNAIDS data to determine country eligibility for funding. Civil society and communities rely on UNAIDS data to apply for harm reduction funding from international donors, including the Global Fund. This creates a vicious circle that drives funding crisis for harm reduction.

SECTION 2: People-centered response to HIV – key emerging messages

Please enter the main messages coming out, up to 5 points maximum per section

REACHING THE PERSON	
<p>How do we see the current situation?</p>	<ul style="list-style-type: none"> • Approach to harm reduction is diluted by the SDGs and donor commitments. • People who inject drugs are one of the most vulnerable populations and at a high risk of acquiring HIV and HCV infections. Currently HIV prevalence among people who inject drugs is 13.5%, HCV prevalence is 52.3% and HIV incidence is 10% (this differs from region to region with the highest HIV incidence among people who inject drugs in EECA, MENA and Asia and the lowest in Sub Saharan Africa). Because of a high need of services and low investments in them people who use drugs have limited access to HIV and HCV services, including harm reduction outreach and counselling. • Harm reduction services are often only focused on HIV response, leaving behind people who use drugs that are at a lower risk of contracting HIV (e.g. people who inhale drugs). • Very little funding is directed towards civil society and community-led advocacy, especially in relation to creating enabling environment and removing social and legal barriers (e.g. decriminalisation). • People who use drug are often perceived and treated as an isolated community – they need to be treated as a part of the society. Only then we can truly leave no one behind.
<p>What concerns us?</p>	<ul style="list-style-type: none"> • Lack of funding and closing of services for people who inject drugs in the context of donors transitioning from middle-income countries and COVID-19. • Existing services for people using drugs are very HIV centred and focused – harm reduction in much broader than just the nine harm reduction interventions coming from the UNAIDS/UNODC/WHO technical guidance. • Harm reduction HIV response is often limited to HIV test and treat. More people who use drugs die of HCV or overdose. • Majority of international donors focus on funding harm reduction interventions. Very little funding is directed towards removing legal and social barriers, community support and social services. • Coverage of harm reduction interventions is low in many countries. Only 1% of people who inject drugs live in countries with high harm reduction coverage. • COVID-19 brings even more challenges for people using drugs – many harm reduction services are disrupted or are closing down.

<p>What gives us hope?</p>	<ul style="list-style-type: none"> • International focus on eliminating HCV. This provides us with an opportunity to secure additional funding for harm reduction. • Increased number of drug law enforcement officials and religious leaders advocating for harm reduction. • COVID 19 pandemic allowed to start a discussion about a wider meaning of harm reduction and social determinants of health. • Global, regional and national harm reduction organisations and networks are becoming stronger, more professional and united. • Increasing number of governments recognise that harm reduction is not limited to medical responses but also encompasses housing, legal and social care, and human rights.
<p>What constrains our ability to achieve our goals?</p>	<ul style="list-style-type: none"> • Lack of funding • Low coverage of harm reduction services • Lack of disaggregated data/population size estimates in many countries • Limited UN and international donors' leadership on harm reduction on international, regional and national level • Stigma, discrimination and criminalisation

<p>THE STRUCTURES THAT RESPOND TO HIV</p>	
<p>How do we see the current situation?</p>	<ul style="list-style-type: none"> • Despite the fact that many UN agencies (WHO, UNAIDS, UNODC), international donors (Global Fund, PEPFAR, the Dutch Government, philanthropic organisations) and national governments endorse harm reduction in their strategies and policies, the coverage of harm reduction overall is very low. Only one percent of people who inject drugs live in countries with high coverage. • UNAIDS current strategy focus on 90-90-90 deprioritises key populations. The other strategy targets are more or less an add-on after the fact. Countries are not incentivised to report on anything else. • "End of AIDS" is a distraction from real aim of creating a sustainable response. Some countries can on paper get close to 90-90-90 without reaching key populations. Unpack "ending AIDS as a public health issue" to clarify that key populations should be prioritised to achieve that goal. • Targets are poorly defined – countries can pick and choose what they want to focus on and where to invest money. This might lead to investing in programmes not where the epidemic is. • Chronic lack of funding for prevention. Prevention efforts are entirely focused on sexual transmission. • UNAIDS should create a clear process for prioritising which countries are eligible for HIV funding, and which populations/interventions are prioritised within countries, that includes ethics - not just "investing for impact" (which disfavors small or hidden populations). The process

	<p>should be transparent, inclusive, human rights-based and accountable.</p>
<p>What concerns us?</p>	<ul style="list-style-type: none"> • Even if some countries include harm reduction in their national AIDS strategies, there is a lack of data, especially on population size estimates, HIV prevalence and HIV incidence among people who inject drugs. • Currently countries are only expected to report on two combination prevention interventions for people who inject drugs per year, and can choose which intervention they want to report back on. This leads to some countries choosing to report back on interventions that are not key harm reduction intervention (e.g. needle and syringe programmes or opioid substitution therapy) but general interventions for all key populations (e.g. condoms). • Key populations including people who inject drugs and harm reductionists are not meaningfully engaged in development, oversight and implementation of AIDS strategies including on national level, UNAIDS strategy and international donors' strategies that drive funding. It is crucial to reflect at what stage are above mentioned groups consulted, and with what information? Is consultation a rubber-stamping process? • A lot of resources - finances, staff time, public space, etc. – currently is and will continue to be diverted into COVID-19.
<p>What gives us hope?</p>	<ul style="list-style-type: none"> • UNAIDS Secretariat and its leadership continues to be an outspoken champion of harm reduction on international level.
<p>What constrains our ability to achieve our goals?</p>	<ul style="list-style-type: none"> • Existing data from governments often underestimates size and needs of key populations. UNAIDS is constrained to use government data, but needs to include civil society, academic and other data to disqualify poor data from government. Key populations atlas shows that this is possible and UNAIDS should be given leeway to build on this to develop better and richer data. • Only one percent of people who inject drugs lives in countries with high harm reduction coverage. Despite the fact that half of the countries that report drug use include harm reduction in their national policies, UNAIDS/UNODC/WHO endorses and calls for implementation of harm reduction, the coverage remains terrible. How can we incentivize scale-up of harm reduction? • Majority of people who inject drugs live in upper middle-income countries. The Global Fund is the biggest donor of harm reduction yet because of its eligibility policy that relies on country income level instead of inequality level within countries, the Global Fund is transitioning and withdrawing from many middle-income countries. National governments are not stepping in to fund harm reduction, which results in closure of services for people who inject drugs. • What accountability will there be for HIV donors to align with UNAIDS strategy and report on progress? What accountability is there for UNAIDS for failing to meet current targets? And to whom UNAIDS is

	<p>accountable to? Only to member states and donors or also to key populations that are being left behind?</p> <ul style="list-style-type: none"> • Funding for civil society and community-led organisations is inadequate to sustain advocacy for harm reduction services or enabling environment at country/regional and international level. When the Global Fund or other donor funding for harm reduction services or advocacy transitions out, civil society and community-led groups are stranded. There is an urgent need to get other institutions/donors on board.
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CONTEXTUAL ENVIRONMENT	
<p>How do we see the current situation?</p>	<ul style="list-style-type: none"> • COVID-19 has highlighted health inequalities and the need to focus on gaps in health and community systems. This presents us with an opportunity to revive discussion on harm reduction. • We are seeing a lot of bias against communities of people who use drugs, especially during medicine shortages etc. It points to deprioritisation of services for people who use drugs during the COVID-19 pandemic. • Overall, there has been little change in the availability of harm reduction services around the world since 2014; and funding for harm reduction has flatlined. We are witnessing stagnation due to social norms. • Unsupportive and hostile environment for people who use drugs - criminalisation (also of other populations) is widespread. Many countries are still following ineffective and punitive responses to drugs and some, such as the Philippines, are openly waging the war against people who use drugs. • Governments are willing to provide medicines and services, but not to enshrine rights. Key population services seem to be the first to be cut.
<p>What concerns us?</p>	<ul style="list-style-type: none"> • COVID-19: immediate health outcomes for vulnerable groups will get worse. • Not enough progress for people who use drugs, especially in changing the environment beyond services (employment, social inclusion, housing etc.). • Health funding in countries not expanding to match GDP and increase in country income level. Looking ahead, governments will likely have even less funding available for health. • Key populations are still facing (increased) barriers to engage, especially in the most punitive environments or where resources are limited. • Shifting priorities of donors, perhaps away from HIV / harm reduction. Need to find a balance: COVID is a key co-infection for HIV, and the HIV sector has a role to play in the COVID response - but it cannot be the main focus.

	<ul style="list-style-type: none"> • Resistance and opposition from harm reduction unsupportive countries will remain strong, and they will seek to influence strategy in that way.
What gives us hope?	<ul style="list-style-type: none"> • Increased awareness of the need for investments in health and community systems, and some positive changes in service delivery (peer-driven, take-home doses etc.). • Better recognition of the need for change across sectors. • Opportunity to have diverse voices heard, and to highlight the realities for some populations who cannot socially distance etc. • UHC agenda should improve access for key populations (beyond HIV).
What constrains our ability to achieve our goals?	<ul style="list-style-type: none"> • Criminalisation of people who use drugs. • Fragility of the progress made, and the fact that it is always at risk. • Conflation of drugs and crime - especially within the UN system, with UNODC etc. • Shifting donor priorities, including Global Fund funding policies and withdrawal from middle-income countries. • Political resistance to endorse harm reduction from some countries within PCB.

EMERGING PATTERNS:

- Mixed picture - some important allies, some setbacks (punitive environments/funding for punitive environments)
- Decriminalisation and the enabling environment - criminalisation is hampering efforts.
- Data – there is an urgent need for better data, it need it to be disaggregated and UNAIDS needs to recognise civil society/community data as UNAIDS official data (implications for international donors, especially the Global Fund that uses official UNAIDS data)
- COVID19 is shaking up discussions and presents opportunities and challenges (around the world society is evaluating 'What is risk? What is harm?')
- We need a broader and more specific definition of ending AIDS tailored to most affected populations, including people who inject drugs
- There are issues with indicators and targets - developed in global centres, not taking under consideration realities on the ground, especially enabling environment.
- Donor accountability, how can donors be more accountable to delivering on the global AIDS strategy and invest where matters and where needs are?
- Community-led organizations and civil society leading harm reduction response – need to be fully funded – not only for service delivery but also national/local advocacy (COVID highlights importance of community driven response)

SECTION 3: RECOMMENDATIONS World Café

Please enter the main messages coming out, up to 5 points maximum per section

What are the key recommendations back to UNAIDS in terms of the strategy specifically?	
CONTINUE	<p><i>What is working that we must continue to do?</i></p> <ul style="list-style-type: none"> • Focus on key populations and prevention. This requires collection of disaggregated data on population size estimates, HIV prevalence, HIV incidence, coverage of harm reduction and services for people using drugs as well as arguments for states on implementing harm reduction. • Simplification of complex issues and messages (i.e. 90-90-90), for advocacy and political purposes, these need to be tailored to the epidemic and include enabling environment as a precondition to achieve goals and targets. • Champion rights of people who use drugs and harm reduction on national, regional and international level. • Work closely with the Global Fund and other donors to fund harm reduction services in all countries that require support. There needs to be a common understanding that international donors cannot withdraw from countries without concrete and sustainable plans for continuation of funding for harm reduction. • Connect and cooperate with different communities in national HIV response. Communities and civil society need to be actively involved in discussions and decision-making processes from the beginning.
STOP	<p><i>What must we stop doing, that if we don't stop will ensure failure?</i></p> <ul style="list-style-type: none"> • Prioritising cost over quality of programmes and focusing too much on bio-medical response, commodities and evasion of more political elements of the response (only talking about numbers, not rights). Enabling environment, including decriminalization, needs to be at the front and centre, not replaced with more soft issues of stigma. It's time to stop discussing only positive and beautiful things and to see hard reality. • Imbalance between the epidemiology (i.e. more than half new infections = key populations), and the UNAIDS response / resources and compromising efficiency of HIV response in negotiation with states. Like in Russia, where majority of HIV have injection way of transmission, and UNAIDS invest in working with youth on sexual transmission • Putting drugs together with crime. Drugs need to be placed in health agenda, not in UNODC crime discourse. This links with stopping support for not-evidence based, not-gender sensitive, stigmatising programmes based on morality or traditions.

	<ul style="list-style-type: none"> • Siloed approach - could do more on other co-infections, for example HCV, TB etc.
START	<p><i>What are we not doing that we have to start doing?</i></p> <ul style="list-style-type: none"> • Implement promise to push for support to community-lead programs from up to 30% of all HIV response (including community lead and peer outreach, community-lead monitoring of services. • Work with international donors to provide funding and support to national and local community advocacy for better services and HIV response programs, including for enabling environment. • Prioritise work in regions and countries with highest burden of the epidemic. Response needs to follow the epidemic, not the Official Development Assistance funding priorities or mathematical modelling priorities. • Use as official UNAIDS data, data produced by academia, civil society and community-led organisations. • Be accountable and transparent about the failure to meet current targets and learn from these failures. • Strengthen the capacity and focus on key populations throughout the Secretariat - in Geneva and in country and regional offices countries.
What is the one key recommendation you want to reiterate for strong consideration?	<p>UNAIDS should create a clear process for prioritising which countries are eligible for HIV funding, and which populations/interventions are prioritised within countries based on actual needs, not on country income status income. This includes consideration of ethics - not just "investing for impact" (which disadvantages criminalised, vulnerable and hidden populations).</p> <p>This process should be transparent, inclusive, human rights-based, accountable and include meaningful consultation with key affected community and civil society groups, who are also part of the decision-making process from day one.</p> <p>This HIV funding must include funding for civil society and community advocacy, including most importantly decriminalization and an enabling environment. Prioritisation processes must use disaggregated data. If governments can't provide disaggregated data, other sources of data (civil society/community/academia) must be used.</p>

Please share with us any references you think would be useful for the Strategy Development, such as examples of case studies that illustrate the challenges or recommendations you outlined in the discussion report.

Please also share a list of names and email addresses of participants who would wish to continue to be informed of the Strategy development process. Note names and contacts will not be shared publicly or with any third party.

You can send us additional documents via e-mail strategyteam@unaid.org

UNAIDS

20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 3666

unaid.org