

UNAIDS STRATEGY DEVELOPMENT

UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Country: Global

Organizer: WFP, UNAIDS, UNHCR

Date: 8th September 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@unids.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:, WFP, UNHCR, UNAIDS

Date of discussion: 8th September 2020

Theme to be discussed: HIV Response in Humanitarian Settings

Participants (types of organizations participating):

- UN organizations
- NGO/IGOs
- Academia
- Civil society organizations
- Grass-root organizations

Organizations that participated: MSF, The Global Fund/COE Team, Eastern Deanery AIDS Relief Program, UNFPA, CDC US, IRC, UNAIDS, WFP Panama, IFRC, CDC Mozambique, Medicus Mundie Switzerland, WFP, UNODC HQ, IAWG, Global Fund, UNDP, MMS, UNFPA, WHO HQ, UNDP Geneva, UNHCR Regional Bureau EHAGL, IOM HQ, Women's Refugee Commission and IAWG, IOM.

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)

- In line with the 2030 goal of ending the AIDS epidemic, the 2016-2021 strategy needs to be reviewed to inform the next strategy. A review of the current situation indicates that while progress has been made in the form of improving access, awareness, and reducing mortality rates, the pace of the progress is still below target and humanitarian settings are lagging even further behind.
- One third of PLHIV have no access to treatment; this includes people living in humanitarian and conflict affected contexts, key populations, adolescents, children and men.
- Misalignment and lack of integration of HIV at various levels is a major roadblock. For the global agenda to translate to on the ground realities, national and international priorities and responses need to be aligned. HIV strategies need to be “in sync” with global frameworks like SDGs and UHC, and with other closely interlinked health areas such as TB and SRH. Social protection instruments must be integrated into emergency settings.
- One third of the worlds PLWHIV have no access to treatment; they include particularly people living in humanitarian (including conflict affected) contexts, key population adolescents, children, and men. In humanitarian settings, mobile populations such as refugees, migrants caught up in humanitarian situations and IDPs face unique challenges in accessing prevention, treatment and care services. Globally, the response to reach key populations been grossly inadequate despite the knowledge that a staggering percentage of new infections is among key populations and their sexual partners, including in humanitarian settings
- Both demand-side initiatives which increase service take-up and supply-side initiatives which increase access to quality HIV prevention, treatment, care, and support are required. A component of addressing the above-mentioned populations is addressing structural barriers such as gender inequalities, poverty , stigma, and discrimination. Furthermore, access to basic needs in these populations is often compromised including shelter, water and sanitation and food security. Community-led and peer-led initiatives have proven to be effective and need to be leveraged. At the same time, improving upon proper training of field actors, access, supplies and raising community awareness needs to continue, especially given the positive results they have shown.
- The coronavirus pandemic has not only exacerbated existing conditions from both health and socio-economic perspectives but is also seen as a cause of resource diversion from HIV. This can be partly attributed to the siloed views of health issues. The linkages between them need to be recognized so that they can be addressed in a holistic and more efficient manner. Apart from a need for quicker and more dynamic responses, this must be grounded in a people-centered and rights-based approach. Better collection of data, advocacy and enlargement of fiscal space are prerequisites for the scale of interventions required to achieve the 2030 goal of ending the AIDs epidemic.

SECTION 2: Key emerging messages

The key messages are divided into two sections: outcomes and processes. The outcome section reviews developments relating to results and targets while the process section is more oriented towards operations and procedures relating to HIV strategies in humanitarian settings.

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

OUTCOME	
How do we see the current situation?	<ul style="list-style-type: none"> • 33% of PLHIV are not on treatment. This especially includes key populations and other vulnerable populations such as adolescents, children, men, conflict affected populations, refugees, migrants and IDPs. • In 2019, approximately 1.7 million people acquired HIV worldwide. • Covid-19 has exacerbated inequalities and marginalization. It has led to a disruption in services, violation of rights, dire socio-economic consequences, and may potentially divert resources away from HIV. • Among marginalized groups, a higher prevalence of violence is linked with higher rates of HIV infections. FSWs are 30 times more likely to get infected than the general population. There has been little progress on coverage of actions relating to health and protection of key populations in humanitarian settings
What concerns us?	<ul style="list-style-type: none"> • The rate of new infections exceeds the 2020 target of limiting new infections at 500,000 by over three times. • HIV infections are increasing in MENA, Eastern Europe and Central Asia, and Latin America. • Though mortality has decreased for PLHIV, it is still high—many of these deaths are preventable. Furthermore, a significant (40%) proportion of people who die from AIDS die from TB. • There is a lack of focus on key and vulnerable populations and PLHIV in emergency and fragile contexts. Key populations and their sexual partners make up 62% of new adult HIV infections globally. • In SSA, young women and adolescent girls disproportionately accounted for new infections (1 in 4) in 2019. At the root of much of this is gender-based violence and inequalities.
What gives us hope?	<ul style="list-style-type: none"> • HIV infections are decreasing in Southern Africa • Combination prevention has been proven successful when applied but needs scale up.

	<ul style="list-style-type: none"> • Though the rate of new infections is still above target, it has declined by 23% in 2019 since 2010.
What constrains our ability to achieve our goals?	<ul style="list-style-type: none"> • A lack of overall integration within the system has prevented the realization of on the ground action. The humanitarian response, the global agenda and goals are often not aligned with national government priorities. There is also a lack of synchronization between interlinking health areas and the multiple global frameworks which often work towards similar goals. This has led to inefficiencies. • Lack of capacity and willingness to engage with specific population groups, particularly key populations amongst humanitarian providers • The lack of political advocacy for key populations owing to stigma and for mobile populations due to challenges of neglect and responsibility and oversight for mobile populations. • There is a lack of enough funding. The attention demanded by Covid-19 may exacerbate this.

PROCESS	
How do we see the current situation?	<ul style="list-style-type: none"> • Currently, there exists a disconnect between targets and SRAs. For example, there is a separation of measures addressing treatment and prevention for young people • Covid-19 is being treated as a separate health emergency. This speaks to the larger issue of viewing interacting health areas in siloes. For example, HIV closely relates to SRH and TB. The current situation is therefore failing in taking a more holistic perspective to health responses, without which benefits of synergies and efficiencies are lost. • Key, mobile, and vulnerable populations continue to be inadequately addressed. Like most shocks, the pandemic has disproportionately affected these population segments. Within the harsh realities of emergency and humanitarian settings, there is an urgent need to step up efforts to reach them and to address their health needs including but not only HIV
What concerns us?	<ul style="list-style-type: none"> • HIV strategies tend to be focused on the national context only and mobility is insufficiently considered, leading to the exclusion of humanitarian and other mobile populations. They are seldom included in national emergency preparedness plans and are often not even given the opportunity to represent their communities in discussions. • Global-national asynchrony is frequently reflected in lack of policy commitment at the national level. This creates inconsistencies across the board for efforts which may have started but are not continued. Without government budgets, donors play a vital role. However, there is lack of coordination between donors and health actors too.

	<ul style="list-style-type: none"> • Among demand-side problems is the difficulty of maintaining a continuum of care. Arrangements for HIV ART medication to be delivered directly to homes and distributed in bulk (multi-month prescriptions) are not opted for due to the stigma and discrimination that PLHIV face. This is exacerbated in urban settings, where overcrowding in housing is common and there is a lack of private space. Similarly, take-up issues are seen among refugees in urban settings who refrain from seeking treatment owing to the fear of being sent to refugee camps. • Among supply-side problems, there is lack of properly trained staff. Delays in responses and late consideration of HIV in emergency responses are causing deaths which are preventable. Sensitization training is also required and efforts to improve provider attitude. There is a lack of psycho-social support groups. Availability of medicine supplies such as ART needs improvement. • The one-size-fits-all approach taken in many situations ignores the importance of contextual factors. Attempts at duplication can be detrimental.
<p>What gives us hope?</p>	<ul style="list-style-type: none"> • The previous strategy was rightly grounded in an RBA and the innate dignity of all people. Its links to the SDGs also ensured that the HIV strategy was considered within the global development agenda. This is a crucial starting point that can be built upon, especially in terms of its implementation in the new strategy. • The renewed focus on healthcare due to Covid-19 can be taken as an opportunity to better position the HIV response within the broader health sector. • Combination prevention using structural, behavioural, and biomedical approaches have worked and seen marked improvement in preventing new infections. • Extensive technical knowledge is already present in the abundance of toolkits and field manuals, such as MISP and ASRH Toolkit for Humanitarian Settings. These have integrated the HIV strategy with broader SRH in humanitarian strategies and placed emphasis on key and vulnerable populations such as adolescents. These have to now be properly leveraged and integrated into the strategy. • Access to treatment and community knowledge and awareness have improved. These efforts must be maintained. • Community and peer-led initiatives have been successful in ensuring better reach of HIV programmes to key populations. They give stigmatized and criminalized groups ownership and enhance their capacity in taking the lead in these programmes. Such a bottom-up approach needs to be implemented much more extensively in the next strategy.

What constrains our ability to achieve our goals?

- There is a lack of integration at various levels:
 - At the broader level of agenda-setting, the HIV agenda is not sufficiently integrated with broader health agendas such as UHC as well as with agendas from other sectors such as the Global Compact for Refugees and UHC Global Action Plan. This will facilitate the inclusion of the most vulnerable populations in HIV programming.
 - There is also a lack of integration of HIV into other health services in humanitarian settings. This is necessary to ensure both the reduction of preventable deaths (as HIV response can be timely) and a recognition of other and related health issues that vulnerable populations may face.
 - The global dialogue and agenda are insufficiently incorporated into national strategies due to which we do not see translation into action on the ground.
- Stigma and discrimination remain at the root of insufficient action on the part of service providers, especially with regards to key populations, and uptake on the part of PLHIV. Additionally, criminalization for key populations often leads them to be excluded from the HIV strategy.
- There is a lack of enough data, particularly of mobile individuals and communities. This is in part due to the sensitive nature of data collection on HIV. This again stems largely from the stigma and discrimination PLHIV experience that makes testing and/or disclosing their HIV positive status challenging.
- Governments are unwilling to take responsibility for mobile populations such as refugees, migrants and IDPs. This is exacerbated by the invisibility of such populations in data and statistics, on which funding and support rely. This effectively excludes them from HIV and broader SRH services.

SECTION 3: RECOMMENDATIONS World Café

Please enter the main messages coming out.

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"> • We must keep fighting for visibility and space for people living in emergencies and fragile contexts. • The continued adoption of a rights-based and people-centred approach as well as inclusive language is crucial to addressing stigma and discrimination. It also calls for creating greater fiscal space that is so desperately required for effective HIV programming in emergency and fragile contexts. • We must continue to focus on the basics—service and delivery, awareness raising and psychosocial support groups—especially in refugee camp settings, and stigma around HIV remains. • Community engagement and peer-led processes have worked and must continue. This includes engagement from the faith-based sector, which can be effective once trust is established that conversion is not a motivation. • The plethora of technical guidance, toolkits, and field manuals for emergency and fragile contexts must be incorporated into the next strategy. • In urban settings, factors such as overcrowding along with the stigma and discrimination PLHIV experience hinder the continuum of care. We must continue to address these contextual and structural barriers.
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"> • We must stop perceiving health and other emergencies as threats which divert resources from HIV programming; they are opportunities to better integrate HIV into the broader health and humanitarian agendas. • Amongst local staff, misinformation and the perpetuation of stigmatizing perceptions have to be stopped through sensitization training. • We need to stop a broad, one-size-fits-all approach – contextual understanding is crucial for more accurate identification of vulnerable populations and effective programmes. • The high mortality rates of PLHIV in emergency settings, which result from addressing HIV too late in the response and insufficient medical support staff, must be addressed. • We must stop perceiving key populations as simply contractors and transmitters of HIV; they are not simply the key to ending HIV and have

	<p>to be seen in their own right. Truly implementing a people-centred approach means ensuring that the focus is not narrowly on HIV but on the other health needs of these populations.</p>
<p>START</p>	<p><i>What are we not doing that we have to start doing?</i></p> <ul style="list-style-type: none"> • Refugees, migrants and IDPs must be explicitly included in the narrative and in national HIV strategies and Global Fund Applications. This involves their representation throughout the policy cycle. • Need to start better aligning with national strategies, specifically to include innovative financial mechanisms to reflect PLHIV in humanitarian settings. • Support and technical assistance should be extended to governments to include contingency stocks and preparedness plans in national strategies in case of emergencies, like in disaster settings. These should include drug flexibility modalities and structures (such as on-site medicine stocks). • Considering the Covid-19 pandemic, faster, dynamic, and context-specific responses are required. With the recognition of the dual burden, advocacy for concentrated joint efforts to counter any resource diversions faced due to siloed allocations is recommended. • Continuity of care is crucial to ensure effective treatment. This is particularly challenging with regards to mobile populations. Thus, mobility has to be taken as an important determinant in the new strategy. This will require quantifying the issues they face and finding solutions to reach them. • It is an urgent need for key, mobile and vulnerable populations to be explicitly included in the global and national strategies. This involves making these populations visible in data and statistics by systematically identifying and mapping them. However, notwithstanding the importance of data collection, of greater priority are measures to ensure extreme sensitivity and protection from the stigma that key populations and PLHIV can face. • Decriminalization of key populations is necessary to enhance the effectiveness of HIV programmes and increase uptake of key services. • While adolescents are certainly important vulnerable populations, special care should be taken to ensure that children are not left behind. • Minimum packages of care that address SRH more holistically need to be more readily available. This includes condoms, lubricants, post-abortion care, STI's + HIV care, PrEP and sexual violence care. • To improve follow-up, broadening reporting frameworks for the health sector and cross-referencing M&E frameworks across agencies can be beneficial.

<p>What is the one key recommendation you want to reiterate for strong consideration?</p>	<ul style="list-style-type: none"> • The HIV global agenda and strategy needs to be integrated at various levels: <ul style="list-style-type: none"> ○ Updated data on HIV risks and vulnerabilities, coverage of services and disaggregation of key global goals for humanitarian populations is needed ○ A concerted effort to scale up services to address the health and protection needs of key populations in humanitarian settings ○ National and global priorities and responses need to be aligned for dialogue to translate from global level to field level. ○ Alignment of strategies to the triple nexus to achieve synergies between humanitarian, development and peace goals is advised. This includes incorporating global frameworks such as SDGs, UHC and GAP. ○ Greater integration of HIV with TB and sexual and reproductive health in humanitarian settings for greater impact and cost efficiencies. ○ Social protection instruments need to be integrated in humanitarian settings for broader programme and policy coherence and effect, especially within the context of COVID-19, which has illustrated the need for strengthening social protection systems, including the set of minimum standards known as “floors”. We must start to address people’s basic and changing needs and vulnerabilities, including refugees, asylum seekers, migrants and populations (link to UNAIDS Call to Action on social protection here).
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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.

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

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