UNAIDS STRATEGY DEVELOPMENT

UNAIDS STRATEGY REVIEW:
Focus Group Synthesis template

Country:	Global: South America, Asia Pacific, India, and Africa
Organizer:	Frontline AIDS
Date:	19 August 2020

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Please use the template to organize your feedback from the session. Please keep responses succinct and as clear as possible to ensure our synthesis reflects 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@unaids.org***

Would you accept for UNAIDS to make your report publicly available: Yes

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

Organization leading discussion: Frontline AIDS

Date of discussion: 19 August 2020

Theme to be discussed: HIV Prevention

Country, regional, or global focus: Global: participants represented organisations from Africa, South America, India, and Asia-Pacific region

Participants – List of participants have been submitted to UNAIDS Secretariat and is not available for the general public due to the nature of the informed consents given by the participants. We thank all participants for their valuable contributions to this report!

The focus group discussion was hosted by Frontline AIDS on 19 August 2020 and included partners and networks globally. Continents represented included Africa, Latin America, and Europe. The focus group facilitator was Cecelia Millado, an Associate of Frontline AIDS. The focus group was facilitated virtually via the Zoom platform and included breakaway groups to enable participants to engage with the required questions in smaller groups. Each session started with a brief presentation by Frontline AIDS providing a context on the topic to be discussed. Interpreters were available for both French and Spanish speaking participants. Participants played an active role in deciding on the recommendations, as well as in selecting the final recommendation for each focus group discussion.

Introducing the theme

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

Clare Morrison, Senior Advisor: HIV Prevention at Frontline AIDS welcomed participants to the session. During her introductory remarks, she explained the rationale for the focus group, and the

crucial role prevention plays in reaching the 2030 goal of ending AIDS. Her presentation, raised the following points:

- We have collectively failed to meet the 2020 targets for reducing new infections, in fact in some regions and among some communities, new infections are still increasing. As such we find ourselves in a prevention crisis, one that is likely to be exacerbated by the impact of COVID-19.
- There have been some promising developments in recent years, such as the expansion of new ARV-based prevention tools (e.g. dapivirine ring, new injectable forms of PrEP), which, if taken to scale, could have a siginificant, positive impact. However, biomedical interventions alone will not close the gap.
- Key populations (such as men who have sex with men, transgender people, sex workers, people who use drugs and people living with HIV), as well as adolescent girls and young women, and other marginalised groups still struggle to access basic HIV prevention services. This is partly due to the existence of harmful laws and policies, which fail to address their needs, and the reluctance of some governments to tackle unequal gender norms and high levels of violence and stigma towards these groups. Where HIV prevention services do exist, they are often of poor quality.
- Community-led organisations play a critical role in ensuring access to HIV prevention especially among those hardest to reach. However, most key populations programmes continue to be funded though international donors. Many countries still do not have a social contracting mechanism in place. As a result, governments are not able to adequately compensate, or even recognise, the valuable work being done by civil society at the grassroots level.
- Funding for the HIV-response in general, and prevention more specifically, is stagnating. The financial resources allocated to HIV prevention programmes are insufficient to meet most countries' HIV prevention financing needs. This is only going to get worse post-COVID-19; as domestic resources are squeezed, and competition for donor funding increases.

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	
How do we see the current situation?	• Existing inequalities have been exacerbated by COVID-19. It is becoming increasingly difficult to deliver basic HIV prevention services, such as condom programming, education and/or risk reduction counselling, ARVs, HIV testing etc. At the same time, the needs of key and marginalized populations are now broader than ever. Many people are struggling with sudden unemployment, limited access to safe spaces or support networks and food insecurity. For many it is now a question of survival vs prevention. • As such, we must work to adapt our HIV-prevention services: we need to expand and integrate services so that they address people's most pressing needs. Wider socio-economic and mental health support must be delivered alongside traditional packages of HIV prevention and SRHR services. We also need to think about how we can sustain these services long-term. • A decline in donor resources is negatively impacting community organization's ability to reach key and vulnerable populations. Funding for essential work has already been delayed, put on hold, or diverted due to COVID-19. • Unequal access to funding, and the unequal distribution of funding to governments and larger civil society organisations, has had a negative impact on community organizations who work at the coalface of HIV prevention. • Additional resources for advocacy are required in countries where donors and other institutions are leaving, to ensure that the needs of the most marginalised are addressed and included in national prevention responses. This includes long-term funding for advocacy, community mobilisation, community monitoring, and public communication/campaigns.
What concerns us?	• We continue to miss the global and national HIV prevention targets – event though we know what needs to be done. Yes, prevention has been given more attention by UNAIDS, but they must commit to maintaining this focus, especially when we are still so far off track. • Sustaining/ continuing services in countries where governments are nearly bankrupt - or in debt - and where formal health services are collapsing under the strain of new health threats. • Questions raised over the ability of governments to deliver health services. Trust in governments are declining, leading to a higher

	demand for responses from civil society and community-led organisations who are often under-resourced. • Concerns about a rise in mental health challenges among young people and marginalised communities, who are struggling to access care and prevention, especially because of COVID-1 which has shifted the focus and limited resources from HIV prevention. Additionally, mental health is often not recognised as part of the prevention and care services by heath facilities. • COVID-19 has shown that technology and virtual communication platforms will form part of the “new” way forward, but often these platforms are not accessible to key populations, or those living in more rural or isolated locations.
What gives us hope?	• Community-led organisations have shown great resilience and have developed innovative service delivery strategies to respond to the challenges posed by COVID-19. This includes ensuring multi-month drug dispensing, piloting take home methadone schemes, and implementing peer-distributed naloxone. These innovations led by key population networks and community-based organisations have led to changes in the way WHO designs its guidelines. Progress which arguably would have taken much longer, pre-COVID-19. • Service delivery is now being approached much more holistically, given the diversification of services delivered to key populations, such as mental health services. • We have a huge number of resources on prevention, and COVID-19 is presenting us with new ways to deliver these services, such as integrating the use of technology into HIV prevention service delivery. • We are seeing the continued emergence of new HIV prevention technologies like the Dapivirine Vaginal Ring. There is hope that this tool will be properly rolled out and implemented, and that ALL women will be educated on the benefits of this technology, and be able to access it, if desired.
What constrains our ability to achieve our goals?	• Governments must commit to facilitating new research studies to assess the impact of COVID-19 and work to remove political barriers that limit access to prevention and treatment for key populations. We know from our own experiences, for example in Latin America, where HIV prevention services which used to reach more than 100 people, are now reaching a maximum of 40 people. How can we learn from other organisations/countries, to overcome these problems? • Governments are opportunistic and lack transparency when it comes to implementing policies and programs for the most marginalised. Often their approaches are not evidenced-based and lack scientific grounding or research.

	• The affordability of HIV-prevention and treatment medication is another challenge. We need to be able to access medication and other prevention tools and commodities at more affordable prices. • Governments are not considering new technologies and innovations to improve access and delivery of services to marginalised groups.

THE STRUCTURES THAT RESPOND TO HIV	
How do we see the current situation?	• Communities play a great role in the HIV prevention response; but are not placed at the centre of policies and strategies designed to address their needs. Agencies and governments often call on communities to provide services or link people to care, but communities are rarely asked to develop strategies or programmes; instead, communities are consulted afterwards, merely to rubberstamp responses or strategies. • We want communities to be part of the whole process, including the design, implementation, evaluation and critique of strategies, policies and programmes that are developed to ensure that they are responsive to the needs of communities and marginalised groups. • Communities must be represented at the highest level, to ensure their voices and needs are met. This representation must go beyond tokenistic invitations to join Technical Working Groups and programme management boards and must be supported to meaningfully engage and participate in these spaces. • Communities must continue to play the role of watchdog regarding the violations of human rights in certain countries; alongside decision-makers and other monitoring bodies. As human rights watchdogs, communities would be able to ensure their inclusion in the drafting of policy and legislation; and monitor whether implementation entrenches or prevents human rights violations.
What concerns us?	• COVID-19 has increased poverty and instability in countries: Although key populations are being recognised in terms of HIV prevention, they also need to be able to act as activists during this time of the pandemic. We are concerned that key populations are not, and will not be reached during this pandemic, because of declining resources, restrictions on movements and the economic impact of the pandemic. • Criminalisation is still an issue when it comes to designing comprehensive packages for key populations. Often it is the government who leads of the design/sign off these packages. As a result packages are often not comprehensive, for example, clean needles, and other preventative measures for people who use drugs are not included. • The quality of data being generated and used to monitor the global HIV/AIDS response: the lack data on key populations (collecting

	disaggregated data, conducting accurate size estimates, tracking programme coverage, conducting hot-spot mapping, measuring programme quality). Without accurate data we cannot measure our impact on key populations, or properly design, implement or monitor programmes effectively. • As a coordinating body, UNAIDS should ensure broader community consultation, and not just invite the same people to consultative processes; this is wasteful expenditure, does not promote representation, and as such, limits communities' abilities to influence the bigger agenda. • The lack of follow-up and implementation of signed declarations by member states e.g. West African Regional Dakar Declaration, regarding key populations signed by Ministers of Health. Although they acknowledged that communities are crucial in the response to HIV, there has been no concrete implementation of this declaration.
What gives us hope?	• Communities are doing a lot of work to prevent HIV-infection, and we have collected evidence to support the importance and continued role of communities in wider consultative processes: including at the regional, international, and national levels. • The significant contribution by key populations during COVID-19, has highlighted what a more human-centered approach would look like. For example, that such an approach would consider mental health, and include peer psycho-social support services. • We must build on this achievement by communities, and advocate that this acknowledgement should translate into investment. Donor strategies (PEPFAR and Global Fund) will be more effective if they invest directly into communities. • Strategies are starting to include indigenous responses to prevention, and there is evidence to support its efficiency. Thus, it is wise to invest in communities; they can do more with less. • The innovation in service delivery to key populations, brought about by COVID-19, is inspirational, and it is good that the World Health Organisation is now advocating for the inclusion of these innovations. For example, multi-drug dispensing is now included in HIV prevention and treatment designs. These advances could have taken longer, had it not been for the urgency brought about due to COVID19.
What constrains our ability to achieve our goals?	• The uncertain funding environment, in part due to lack of action on commitments, causes doubt that key populations will receive continued services. This may lead to a forced return to old ineffective ways and we will lose the value of innovations initiated during COVID-19. • We are witnessing a decrease in political will to address the issue of HIV/AIDS; this is linked to unstable political contexts, decreasing democracy, and shrinking civil society space in some countries. • HIV responses are not always delivered using a human rights-based approach. As activists we need to consider aspects of democracy

	within our work, and join forces with other movements, such as the good governance and the women's movement. • The impact of COVID-19 on economies in developing countries concerns us: we have learnt that during such pandemics, the vulnerable will suffer, and this has already been apparent in many developing countries.

CONTEXTUAL ENVIRONMENT	
How do we see the current situation?	• In some countries, like Zimbabwe we were happy with the progress being made on prevention; but COVID-19 contributes to creating an increasingly difficult environment and threatens to undo some of these gains. Governments are becoming increasingly repressive and this results in a shrinking space for a civil society, and limited opportunities for community mobilisation. • HIV prevention activities disappeared during lockdown condom programming, basic ARVs and testing access is now restricted and there is a lack of access to basic information services. • It is difficult for communities to access relevant services, due to the restriction of movement, and as such, service continuity is under threat. • We are experiencing a constrained working environment; hospitals have been turned into COVID-centres, leading to decreased HIV testing • COVID-19 is having a negative economic impact – we are witnessing rising unemployment; financial resources are exhausted among the key populations, particularly sex workers – this has an impact on condom use and prevention services need to be adjusted accordingly.
What concerns us?	• There has been a decrease in HIV-services as health workers are now more focused on COVID-19 patients; HIV facilities have been converted to COVID-19 support activities; the stock-out of medicine has worsened; and in some countries the National Health Insurance wants to stop HIV-services, which sets a dangerous precedent. When running HIV services, there is little protection in place for health workers and peer-outreach workers, which makes them vulnerable to COVID-19. • We have witnessed a rise in mental health problems like depression and anxiety, across the countries, particularly affecting those on treatment and care, and those who have had to return to unsafe spaces and unsupportive families. • Economic vulnerability means that people rather use their money for food, than preventive measures such as condoms.

	• In many countries, the ability of communities to render HIV support services are restrained by an oppressive legal environment. It has become increasingly difficult for community organisations to advocate for changes in these contexts, as the focus of many governments is now primarily on COVID19. • The use of virtual spaces can also close space and decrease civil society representation; as not all communities have access to technology or data; if these needs are not addressed we will see a reduction of community participation in these processes.
What gives us hope?	• In some countries like India, we are seeing an increase in regular dialogues between the governments and civil society on COVID-19 and wider health issues; and we hope these discussions will translate into policies and action post-COVID. • It is important that UNAIDS continues to facilitate policy dialogues between communities and government representatives. By creating increased spaces for communities to showcase evidence from the ground, and present this to governments and wider institutions. • Government and community are collaborating on new M&E tools and frameworks that help to capture impact of community work on key populations. • The expansion of key populations forums in some countries. Whilst these discussions are typically held at national level, this year we have seen it translate to sub-national level – thus government and different communities are coordinating more effectively. • In some countries, COVID-19 has propelled a more integrated response to HIV service delivery, and at national level there has been a push for this. This makes us hopeful for enhanced access to HIV services for key populations.
What constrains our ability to achieve our goals?	• We are experiencing limited financial resources because of COVID-19 pressure and plans need to be developed to address this so that it does not continue post-COVID. Domestic resource allocation is also not prioritising HIV and more needs to be done to keep HIV on the agenda. • COVID-19 overtook the public health agenda and as a result innovation within HIV is slowing down. Those who work with HIV also need support, as they work under challenging conditions exacerbated by COVID-19, especially at community level. • We are witnessing the shrinking civil society space in many countries - different civil society groups need to coordinate better to maintain space for work. • Certain countries still have legislation and policies that criminalise certain key populations, such as sex workers and men who have sex

	with men, restraints community organisations to reach or provide these key populations with HIV prevention services.

EMERGING PATTERNS:

- Transgender people and other key populations are being excluded from HIV-services; that their needs are not reflected in national health data, and as such, that their health and needs are not recorded, or included in response strategies.

- COVID-19 has had both a positive and negative impact on prevention in various countries; negatively it has impacted on the redirection of health services to COVID-patients and a decrease in HIV-services. At a positive level, countries have witnessed innovative development of prevention strategies to reach key populations and marginalized communities. Advocacy is needed to continue the scale up of services and increase access, through challenging harmful laws and policies. At the same time, vigilance is needed to ensure that HIV prevention budgets are not decreased during and post-COVID.

- Community organisations are witnessing a rise in mental health concerns of key populations, because of the lockdown in countries, and their restricted access to services. Organisations feel that the COVID-19 response is showing that a holistic, as opposed to a bio-medical response, is needed to prevent, treat, and care for people living with and most affected by HIV.

- There is a need to recognize civil society as a key partner in strategies, responses and services aimed at HIV prevention. Organisations strongly feel that the practice of developing policies without communities should stop, and that more should be done to ensure the facilitating of community participation in decision-making. In addition, the shrinking space in many countries is criminalizing the work of these organisations; or rendering then unable to do their work.

- The disastrous economic impact of COVID-19 on the most vulnerable, has created an increased set of needs that need to be met by communities and community organisations. Not only do communities work with restrained resources, many donors are exiting or not directing resources towards HIV-prevention. There is a need to ensure that donor resources flow directly to communities, and not just to governments and agencies.

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	*What is working that we must continue to do?* • Continue to prioritise key populations needs and ensure access to services for them at a decentralised, community level; working with and supporting community-based organisations to continue to reach

	these groups; and advocating for decriminalisation and an end to discrimination. • Continue to democratise the public health system, the decentralising of health services, and investment in community led services that has been strengthened by recent service delivery innovations due to COVID-19. • Continue to advocate for approaches that promote the principle of by communities, for communities and leadership by communities; including communities serving as human rights protectors and those that are innovating at a local level.
STOP	*What must we stop doing, that if we do not stop will ensure failure?* • Stop allowing governments to use laws, policies, closing of space and allocation of resources to discriminate against and marginalise key populations and communities. • Stop playing into the hands of governments on innovation; and only funding and supporting innovations by large agencies and in a silo approach which ignores communities. • Stop delivering services and using approaches that only recognise and fund large organisations, at the expense of community driven initiatives. • Stop Implementing advocacy based on non-evidence-based data and ensure evidence from communities are the drivers of policies.
START	*What are we not doing that we have to start doing?* • Start recognising and funding key population-led and community-based initiatives that have made a significant difference in reaching marginalised communities with limited capacity and resources. This includes investing in more innovative and sustainable community-led approaches that reach key populations. There are many examples of “what works”, that now need to be implemented at scale. • Start persuading governments to stop using force, and oppressive laws and policies that close space for civil society and which restricts key populations from accessing services. • Start pushing governments to keep HIV on the agenda; and officially recognise community based organisations as service providers, which includes providing them with the resources to enable them to continue the work they are doing to reach marginalised communities. • Start ensuring more accountable political leadership to improve the democratic systems which lack transparency.

What is the one key recommendation you want to reiterate for strong consideration?	**Collectively we have failed to reduce new HIV infections. UNAIDS must take stock of this failure and commit to addressing HIV prevention within its next strategy. To achieve success on this issue, UNAIDS must work with the civil society to reclaim the AIDS response and be more vocal in pushing agenda points that are harder to address. This includes: advocating for the decriminalisation of key populations, scaling up interventions designed to address stigma, violence, and gender inequality, pushing for the inclusion of marginalised groups in national prevention programmes, overseeing the expansion of social contracting, putting community-led responses at the centre of service delivery and fostering a safe and inclusive environment for civil society. To add weight to this agenda, UNAIDS must identify a set of realistic and measurable targets, which address these critical enablers and effectively hold governments to account.**

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@unaids.org***

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