Frontline AIDS Harm Reduction Evaluation

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EXECUTIVE SUMMARY

This harm reduction assessment focuses on progress made and forward-looking lessons learned from Frontline AIDS work through PITCH and IHRP programs over the period 2016-2020. The assessment did a deep dive in five countries – India, Myanmar, Mozambique, Nigeria, and Senegal. A diverse range of grantees, civil society partners, authorities, international organizations, funders, and rights activists provided reflections and feedback for Frontline AIDS to consider as it enters into its upcoming post-2020 harm reduction strategy development process, as summarized below.

Context

Today's harm reduction landscape is a complicated one. There have been meaningful developments at a community level in a number of new geographies over the last years. At the same time there are critical challenges and some stagnation and even steps backward in creating sustained political will for needed harm reduction policy change and implementation. Positive steps over the last four years include the development of networks of people who use drugs, a strong cadre of harm reduction leaders anchored in shared movement values, and increasing numbers of community-based services that are flexible, creative, and resilient. During this same period, significant donor funding supported both expansion of services and advocacy in a number of new countries and regions, and UN bodies came together more intentionally to highlight the failure of global drug policies and the need for pro-harm reduction policies anchored in public health responses.

The more challenging side of this picture is that harm reduction expertise and experience remain concentrated in a few key regions in the world, a number of countries are actively deprioritizing harm reduction under budgetary constraints, some needle and syringe programs across regions have closed, the normative environment has largely failed to shift, and the global funding picture in 2020 is increasingly dire. COVID-19 has also created both more challenges and possibly some opportunities for harm reduction approaches over the coming few years. Given this complexity, the pathway forward for harm reduction is not straightforward and needs to be carefully considered.

Case Studies

Three country case studies anchor the analysis of this assessment report. The case studies sketch out harm reduction journeys and stories in India, Mozambique and Nigeria. In India the importance of inspired, creative leadership is lifted up, showing how informed leaders are absolutely instrumental to successful mobilization and impact. In Mozambique, the important role of Frontlines AIDS guidance is highlighted, opening the door to harm reduction in a new location. In Nigeria in a pretty challenging context, a technical working group across sectors and actors has played a key role.

Key Findings

This assessment exercise identified meaningful achievements of PITCH and IHRP investments in Africa and Asia over the last three years. Frontline AIDS contributions including funding, technical assistance, and a focus on building and advocating for community-based service delivery enabled and nurtured these efforts. While significant impact was achieved, serious challenges exist and remain in the country settings. The most concerning challenges are an uneven awareness, knowledge and buy-in to harm reduction values and philosophy along with varied levels of technical knowledge among the national partners and local groups engaged in many kick-starter and accelerator national settings. A reduced funding landscape in multiplier countries, specifically for advocacy efforts is also concerning.

The future for harm reduction demands some reframing, coupled with working in new, alternative ways. Donors are actively looking to fund at critical junctures, such as gender, sexual health and rights, mental health, universal health coverage, and the interplay and overlap of COVID-19 response and relief with harm reduction. It is a critical moment for Frontline AIDS to reflect on these opportunities to create a new harm reduction strategy that builds on achievements, amplifies Frontline AIDS unique voice in this space, and is flexible and creative in

analyzing the evolving global health architecture where systems, funding, priorities and politics look and act differently, than even a few short months ago.

Frontline AIDS Impact

Frontlines AIDS funding and engagement has been a significant source of support for growing nascent country-level efforts. This support for instance helped the opening of the first needle exchange programmes in Nigeria, and created a remarkable scale-up of services and fertile ground for discussions on decriminalization in Mozambique. In this context, Frontline AIDS high-level technical expertise coupled with experience supporting community-based service providers has been the magic sauce for successful engagement at country level. Convening unlikely national actors strategically together has been and continues to be an important and unique Frontline AIDS contribution to harm reduction advocacy and action.

Local level efforts and interventions in countries have been particularly creative and impactful and partners seek to focus on and ramp up attention at this level in the future. It is at local level where IHRP countries helped to address the previously unmet needs of overdose, hepatitis C treatment, women who use drugs and female sex partners of people who use drugs. In the COVID-19 response there was nutrition aid provided locally in India, and in Myanmar, the start of peer led methadone maintenance programs and practical models of community-based drug treatment.

Capacity – A Defining Challenge on the Ground

Implementing partners and/or local groups in all of the five countries profiled in this assessment struggle with capacity issues ranging from a lack of awareness and buy-in to harm reduction values, to limited technical know-how, to an over-reliance on centralized structures that do not adequately support capacity at community level, to fundraising. Frontline AIDS founding partners are a keystone of success when they have knowledge, experience and interest in harm reduction, but can be obstacles to forward momentum when they have less interest, are overstretched, or actively limiting the space for more natural partners. One on one capacity mentoring and coaching is highly effective and appreciated on the ground. Other capacity strengthening tools are not as developed, including communities of practice and practitioner guides, and are especially needed for use at community levels.

There has been a lot of effort focused on building representational capacity and networking, and much less on organizational development of country grantee partners. Some partners are indicating that organizational development is their top priority moving forward, especially fundraising capacity. The stressed HIV funding landscape including the Dutch MFA withdrawing from harm reduction has signaled that HIV and harm reduction efforts will need to think creatively and look and act differently moving forward. High country-level ambitions are currently supported by small budgets. To achieve desired outcomes, Frontline AIDS will likely need to narrow its niche or geographic footprint, and collaborate more extensively with others to fill prioritized gaps.

Finally, accelerator country designation in Frontline AIDS theory of change doesn't effectively communicate the stage of development of the country, particularly related to internal capacity and policy challenges. It will be important for Frontline AIDS to consider how to best articulate a theory of change for widely varying levels of experience, capacity, and vision within the accelerator country settings.

Funding – Tough Landscape and Worrisome Global Signals

Frontline AIDS has been fundamentally important to both national and global level organizations as a funder of harm reduction efforts over the last years. All interviews prioritized the role of Frontline AIDS in identifying and pursuing funding for harm reduction moving forward. The stressed HIV funding landscape including the Dutch withdrawn from harm reduction has signaled that HIV and harm reduction efforts will need to think creatively and look and act differently moving forward.

IHRP and PITCH have been trying to promote decriminalization, improve access, decentralize services, build capacity, set up and promote community services, and document practices. High country ambitions have been supported by relatively small budgets. To achieve desired outcomes, Frontline AIDS will likely need to narrow

niche or geographic footprint, and collaborate more extensively with others to fill prioritized gaps. The two programmes have not prioritized domestic mobilization of resources. Tackling this complex area will require strategic planning and feasibility analysis, matched with creative thinking and action.

Partnership Moving Forward

Today, donor support globally expects significant and sustained formal and informal collaboration and alliances. At the same time, the global advocacy space has been largely dominated by human rights defenders focused on policy and law, and networks of directly affected populations, with no one representing community-based providers and services.

Frontline AIDS added value is to represent and lift up community-based service delivery experience, testimony and insights into global debates and decision-making. The challenge for Frontline AIDS moving forward is how to effectively merge this focus on community-based experience with working effectively and more intentionally in consortia and alliances.

Reframing Harm Reduction Moving Forward

Today, there is a perception both at global and national levels that harm reduction is not a top priority for Frontline AIDS leadership, and that harm reduction's connection to ongoing Frontline AIDS advocacy and programming in other related issue and population areas is limited. This is seen as a low-hanging opportunity, with many suggesting that Frontline AIDS consider its unique niche in harm reduction, ramp up its own voice and communication in this niche, and connect and stream harm reduction efforts more intentionally throughout the organization.

This assessment found that highlighting people and their stories and experiences in advocacy has been highly effective in changing minds on the ground, as people and faces connect to decision makers within political, security and health spaces in ways that technical issues can't. These stories need to be gathered and amplified moving forward.

Assessment interviews identified significant new junctures and linkages that are ripe for exploring and building out in the near future. These include connecting harm reduction advocacy and programming more proactively across areas of gender, sexual health, mental health, universal health coverage, poverty and rights, and COVID-19 response and relief. Frontline AIDS could bring creative and unique expertise and insights to these junctures, and partners, grantees and peers are excited for Frontline AIDS to consider and build out these directions in its new harm reduction strategy.

Key Recommendations

Based on the harm reduction assessment findings above, please find the priority recommendations below. More detailed discussion of these recommendations can be found in the body of the report.

1. **Create a transformational vision** that is forward-looking, anchored in anticipated needs of the harm reduction field in the coming five-year period, and includes an aspirational roadmap and accompanying capacity strengthening and knowledge sharing plan.

2. Develop strategic criteria for decision making about **where and with which groups to engage.**

3. Prioritize and commit resources to strengthening the **knowledge sharing and learning components** of Frontline AIDS harm reduction work.

4. Position the organization to be a **visible and active thought leader in harm reduction**, while actively reflecting on mindset, skills and ethos that create and sustain effective working relations and welcoming, collaborative environments for partners at all levels.

5. Map out scenarios for successful **harm reduction framing and sustainability planning**.

ANNEX A – COUNTRY CASES

INDIA: FUNDING FLEXIBILITY & STRONG LEADERSHIP REDEFINES MOBILIZATION AND INNOVATIONS

Implementing partner	India HIV/AIDS Alliance (also referred to as Alliance India)
Frontline AIDS Programme(s)	IHRP (HRIDAYA Phase 2) Additionally, leveraging from other funding and programmes, notably WINGS and COVID-19, for harm reduction programming
Amount of budget from Frontline AIDS Programme(s)	US$348,246 from IHRP ▪ 2018: US$150,085 ▪ 2019: US$124,361 ▪ 2020: US$73,800 Additionally, at least US$60,000 from other support
Estimated number of people who inject drugs nationally	850,000[1]
Priorities	• Strengthening forums of people who use drugs at state level • Projects with female sexual partners of males who use drugs and women who use drugs • Overdose prevention and management
Harm reduction progress	Strongly established: multiplier country
Funding tendencies	Significant domestic investment, reducing international funding

CONTEXT

Harm reduction in India has an established history, including state co-financing of efforts, largely through the National AIDS Control Organisation (NACO). Currently in the country, there are 225 opioid agonist therapy (OAT) sites and 266 needle and exchange programming sites[2]. The estimated number of people who use drugs has been grossly underestimated in the past, 177,000 people compared to the new estimate of 850,000. In light of new estimates, the coverage of services is no longer seen as high, just 35 syringes down from 250 in 2017 are distributed per person who injects drugs, despite an increase in the number of needle and syringe programming (NSP) sites in the country[3]. People who use drugs in India are criminalized, in contrast with other HIV key populations.

In the HIV context, it is people who inject drugs who have the highest HIV prevalence among all the key populations with the national estimate above 6% and eight states recording higher levels from 7.7% to 19.8% (Mizoram, Delhi, Punjab, Chhattisgarh, West Bengal, Uttarakhand, Tripura and Manipur)[4]. Additionally, this group is seen as having the lowest progress in terms of HIV care cascade. Most people who use drugs are not dying from HIV - rather from overdose and hepatitis C. India is one of four countries in Asia where some form of naloxone is available, according to HRI. The country's action plan on viral hepatitis, launched in 2019, recognises people who inject drugs as a key population. Furthermore, the country has one of the highest TB burdens globally

[1] Based on data from Dr Rao, National Drug Dependence Center; previous estimates by NACO were 177,000
[2] HRI. Global Status of Harm Reduction 2020.
[3] *ibid*
[4] NACO. HIV/AIDS sentimental surveillance 2016/2017 report

with public health officials aware of the high proportion of TB among people who use drugs. However, differentiated service delivery strategy for people who inject drugs is missing in the national TB programme.

Alliance India seeks to promote community-led good practices by focusing on building the movement of people who use drugs outside the capital city, investing in innovative programming that corresponds to underserved needs, and making the case to get buy-in and financing from the government.

KEY INNOVATIONS & COMMUNITY-LED PRACTICES

1. State forums of people who use drugs and community-driven data

Alliance India has prioritized building the capacity of PWUD on governance, finance, organizational development and mobilization skills. They supported 13 state forums with seed money (under US$3,500 per year) to use for self-defined community priorities. Forums prioritized human rights, decriminalization, TB, hepatitis, overdose, and work in prisons. In addition to the seed grants, Alliance India supported Forum members to create data-driven campaigns with clear asks. This advocacy was also amplified by Alliance India at the national level.

BOX. SIKKIM DRUG USERS' FORUM (SDUF)

In this small North-East state and home to 1,200 people who inject drugs, SDUF helps users to self-organize, links people with services, provides emergency care including support for low-income people, and community-based testing, and advocacy. It currently coordinates over 17 groups of PWUD in the State. These groups raise funds to help their own, for example, with food packages during the COVID-19 lockdown.

SDUF has linked 150 people to opioid agonist therapy (OAT), tested 200 people for hepatitis C and got more than 10 people into hepatitis C treatment with IHRP support. SDUF currently has a female president, a powerful symbol helping to bring WWUDs out from hidden spaces. 15 women were successfully enrolled in OAT during the lockdown.

SDUF is a public voice speaking out loudly in media and with the health department for further decriminalization of PWUD through the Sikkim Anti Drug Act (SADA 2006)[5]. In 2020, SDUF challenged the law on overcrowding of prisons in court and urged releasing of prison inmates with non-violent offences during the pandemic.[6] While the Judge dismissed the case due to technicalities, he urged the State to consider rehabilitation as opposed to criminalization.

SDUF has one staff person, with HRIDAYA supporting their salary; the group does not have a physical office and no other donors. More support is needed to take advantage of recent openings around PWUD decriminalization at the state level, and for expanding harm reduction services, and educating the police.

Fourteen state drug user forums now exist in India - six sustain themselves getting donor and state support to fill gaps in the HIV care cascade, while the other eight, including one emerging WWUDs forum in Punjabi, are new and require nurturing and funding. In some states, forum representatives are part of state-level hepatitis committees. During the COVID-19 crisis, state forums led advocacy to prevent shortages of essential medicines, including antiretrovirals.

Additionally, Alliance India initiated community-feedback mechanisms for harm reduction services in the IHRP supported states. The mechanism assessed sites, highlighting that there was only 50% or less uptake in the best quality OAT services, and pointed out where outreach, psycho-social staff or doctors were insensitive, or medicine underdosed. This data was then shared with NACO and the relevant State AIDS Control Societies and,

[5] Centre for Legal Policy VIDHI. Sikkim's Alternative Model to Tackle Drug Abuse: An Analysis of the Sikkim Anti-Drugs Act, 2006: How a health-based approach to drug abuse has ushered a positive change in Sikkim, September 2020.
[6] Sikkim Drug Users Forum v. State of Sikkim and Others, (PIL), No.7 of 2020 (High Court) also available at https://www.casemine.com/judgement/in/5f9ae8919fca1957f8aa3c0b

according to the national partner, is to be published in a high-profile science journal, one of the first instances of community-led data being profiled in this way.

2. Female sexual partners of people who use drugs [7]

The work among female sexual partners (FSPs) of people who use drugs started in early 2019 in Delhi's Sundar Nagari, in partnership with the Delhi State AIDS Control Society and Bhartiya Parivardhan Sanstha. By October 2020, it reached over 550 FSPs with linkages to services for HIV, SRH, harm reduction, and hepatitis B and C. An estimated one third of the FSPs had experienced gender-based and intimate partner violence, making rights literacy and help with accessing support critical.

This peer-implemented model integrates building self-advocacy capacity, with highly needed nutrition and other basic support during COVID-19. There is some drug use, and high exposure to HIV (4% positive) and HCV in the group. The interviewed site reported supporting 12 women who inject drugs to access OAT. Additionally, the interviewed peers are engaged as a secondary source of support to their spouses in seeking harm reduction services. The pilot, funded under Hridaya, costs US$4,000 a month.

As HIV prevalence was found to be higher in this group than for any other key population in the country except PWID, NACO and several AIDS control societies' decided to support expanding this model to four additional states, including Uttar Pradesh**.** Internet-based trainings and knowledge building for government officials, practitioners, user forums and networks of people who use drugs in other states started in August 2020. According to the national partners, NACO has committed to scale up this initiative either through their own budget or from the Global Fund's HIV country grant.

3. Women who use drugs under the WINGS Programme, Phase 2

Before phase 2, services for women who use drugs were implemented by Alliance India and UNODC, with no direct government support. Having no data on women who use drugs – their number, HIV prevalence and engagement in current services - is part of the challenge. Therefore, in phase 2, part of WINGS supported US$50,000 was invested in evidence building to get buy-in from NACO. Over two years, three CSOs Sahara Aalhad (Pune), Ganga Social Foundation (New Delhi) and Nirvana Foundation (Imphal, Manipur) managed to identify and reach nearly 350 women who use drugs. Alliance India is currently finalizing service operating procedures and guidelines expected to become part of NACO guidance. These interventions have been documented by Frontline AIDS.[8]

BOX. NIRVANA FOUNDATION

In Manipur State, Nirvana Foundation linked community systems strengthening work with enhanced HIV and harm reduction response, adding mental health, GBV-related support and SRHR for women. The project expanded understanding of the Nirvana Foundation staff of specific needs of women who use drugs preventing them from accessing harm reduction – in the past they designed programs from a male perspective.

"One of the women we worked with had been gang-raped, thrown in a drain and people thought she had died. She never reported it to the police. She did not think she deserved redress because she uses drugs. When WINGS started, years after the rape, she was able to share with us and we connected her to counselling and support." (Sobhana Sorokhaibam, Secretary, Nirvana Foundation).

A success for them has been to stop police sexual harassment following their documentation of women abused in police custody. Police leadership committed to suspending officers who abuse women who use drugs.

[7] In addition to a focus group with the project's peers workers and manager, the section used e-news from India Alliance.
[8] Frontline AIDS. Improving health outcomes for women who inject drugs: Case studies from India, Indonesia, and Ukraine, 2020.

Now, Nirvana Foundation is advocating for a number of state programs, State AIDS Control Society's HIV prevention program, Department of Social Welfare and Women and Child's Department -to include women's specific needs[9]. They are finalizing a documentary to strengthen their policy and human rights advocacy. In January 2021, a night shelter will be opened – a demand voiced by women for a long time.

4. Peer-model for naloxone distribution

A study by Alliance India in partnership with the Indian National Drug Treatment Center highlights that in Delhi over the last year, 60% of PWUD witnessed an overdose, with 53% personally experiencing an overdose. There are a number of factors contributing to these high numbers, particularly rates of those injecting alone, use of opioids with sedatives, and fast injecting out of fear of being caught.

COVID-19 significantly increased unpredictability in drug markets, leading to India experiencing even more overdoses. Given this situation, the government of India has become more open to community-based models for naloxone distribution. Building on this development, HRIDAYA reprogrammed funding to procure 2700 ampules of naloxone, with 2400 of them successfully distributed in only three months. These efforts were linked to an ongoing research study, which is about to be published in an Indian scientific journal. NACO is expected to use this data for government programs.

SUCCESS FACTORS

1. Redesigning work: communities at the centre and links with opportunities

> *As harm reduction is becoming more medicalized, we see more setbacks to community-led approaches. We were very careful about using innovation to reinvigorate community-led approaches. We wanted to decipher between community-led and community-based. (National partner)*

In 2017, Alliance India decided to reconceptualize the Frontline AIDS funded HRIDAYA project. While the overall goal – to strengthen community-run approaches, innovating to better meet and address prioritized needs of people, did not change, the design and approaches shifted. The redesign focuses on people who use drugs left behind by HIV programs, and enables them to work on community-identified gaps and solutions.

User mobilization was "decentralized" to states, as Indian health systems are decentralized and opportunities to create practical solutions and responses exist at local and state levels. At the same time, WINGS project phase 2 was also revised to focus on one highly stigmatized and underserved group of women who use drugs, instead of a prior focus on broad groups of vulnerable women.

2. Building buy-in from authorities

Before 2017, NACO was the source of data and innovative thinking on harm reduction in the country. Over the last three years, this has changed, with Alliance India now the organization armed with analysis, UNAIDS data, in-depth understanding of gaps and needs, and real-life experience on what is working and not working on the

[9] Alliance India. Annual Report 2020

ground. Alliance India was also instrumental in pushing to get statistics on the number of people who use drugs in the country right.

This data-driven approach has led to NACO recognizing the importance of prioritizing sexual partners of males who use drugs, and to some degree women who use drugs. Alliance India accomplished this through structuring an inclusive process in selected States with local authorities and communities of people who use drugs to discuss needs, feasibility and cost-effectiveness, and setting up small pilot projects to generate evidence and identify practical models, before rolling them out in a larger way. Similarly, it was helpful to have support from specific State AIDS Control Societies and emphasize work with local governments where they found receptiveness.

3. Dynamic, experienced team and flexibility

Alliance India's harm reduction team of five has particularly strong technical expertise and harm reduction values. In 2017, this strength was reinforced with the addition of a new Associate Director who brought insights from his time at UNODC. The team also includes a global leader of the rights movement of people who use drugs and author of 'Good practice guide for employing people who use drugs'. Alliance India has routinely engaged external research expertise for baseline assessment and evidence building. Staff salaries are supported by Frontline AIDS and the HRAsia project.

> *We managed to do more with this relatively small but flexible funding than with large funding with no flexibility. Built-in flexibility is essential for making sure that services are community-centric. It has been the most useful funding that we have ever received. (National partner)*

IHRP's funding flexibility was critical in being able to strategically reconceptualize when needed and to utilize new opportunities for instance addressing overdose issues, which was strongly recommended from regional forums of people who use drugs, and for organizing COVID-19 humanitarian response.

4. Alliance India's profile, visibility, and partnerships

> *Alliance India has always been seen more as an LGBTI, SRH and inter alia a HIV focused organization. Now we are seen as a leader in harm reduction. There is no debate on who supports community-led harm reduction responses in India. (National partner)*

A national harm reduction network used to exist, but ceased operations when the Global Fund country support for harm reduction was cut some years ago. This left a major void in the country around advocacy and communities of practice. Alliance India, like the Frontline AIDS partnership, was established with a strong agenda on gender, sexuality and rights. The organization traditionally had deep partnerships with networks of sex workers, women, MSM and Hijra. Under HRIDAYA and with a regional Global Fund grant on drug policy, Alliance India morphed into its present profile, as a leader of harm reduction.

In recent negotiations on the COVID-19 Global Fund grant, it was PWUD who pushed hard for Alliance India to receive the US$10 million key population sub-grant. PWUD leadership actually threatened to pull out of the negotiations, if Alliance India did not receive the full amount.

CHALLENGES BEYOND 2020

In a country the size of India IHRP support was only able to cover a fraction of the real needs across the country, with bright spots in several states. The outlook to get these programs sustainable in the pilot sites, replicated elsewhere and reach the coverage needed is not clear. Alliance India has positioned themselves as leaders in

harm reduction, however, at the time of the assessment, they did not know if they would continue to have the funding needed to support such efforts.

The HRIDAYA Phase 2 ends at a critical time. Harm reduction financing from international donors has significantly reduced in India. Since 2017, PEPFAR contribution dropped from approximately US$2 million in 2017 to US$470,000 in 2019 and is concentrated in the North East[10]. The Global Fund's country grant does not currently have a separate component on harm reduction. While there are pockets of progress towards sustainability – including 6 out of 14 regional user forums now sustainable, these are too limited, given dire needs in this country of 1.35 billion people.

Alliance India is trying to find new resources to support causes of people who use drugs. Under the regional initiative HRAsia, they engaged inter-faith communities in promoting the 'Support. Don't Punish' campaign and developed tools to train faith leaders in harm reduction[11]. During COVID-19 response, when women would not come to services due to lack of food and PPEs, the United Religions Initiative and Indo-Global Social Service Society supported 150 families in Delhi with food, PPEs and hygiene kits[12].

Alliance India is closing its regional project HRAsia, with unclear perspectives as the Global Fund decided to focus all multi-country work on South East Asia and sustainability of HIV programmes. HRAsia funded most of the national advocacy in India, while HRIDAYA has focused on support for regional and local levels.

The country offers a number of potential areas for work moving forward. These include improving the link between underserved people who use drugs with existing HIV, TB, and hepatitis C services, continuing to expand the model of regional forums of users, building out approaches among/with women, and overdose prevention and decriminalization. The in-country partners should also focus on advancing the successes seen in some states to engage non-health authorities in drug policy. India now serves as a coordination hub that could expand further the reach of Frontline AIDS to countries with high levels of people who use drugs in other South and Near East Asian countries, where similar opportunities and challenges exist, building on already strengthened connections beween HRAsia with partners in Vietnam, Indonesia and others.

[10] PEPFAR India COP 2017 & amfAR's PEPFAR Country/Regional Operational Plans (COPs/ROPs) database
[11] Alliance India. A Training Manual for the Harm Reduction Champions in the Faith-Based Community, 11 November 2020.
[12] Alliance India. People who use drugs – Somewhere between lockdown and unlockdown, 12 June 2020.

MOZAMBIQUE: OPENING DOOR TO HARM REDUCTION AND DECRIMINALISATION

Implementing partners	ACAM (Associação Comunitária Ambiente da Mafalala), UNIDOS (Rede Nacional Sobre Droga & HIV/SIDA)
Frontline AIDS Programme	PITCH
Amount of budget	US$239,000 in total from PITCH (for harm reduction only) ▪ 2018: US$45,000 ▪ 2019: US$82,000 ▪ 2020: US$112,000
Estimated number of people who use/inject drugs	No national estimates
Advocacy and organizing priorities	▪ Initiating drug policy debate for partial decriminalization ▪ Getting government authorization of and support for harm reduction ▪ Mobilizing financial and other support for scale-up in 2021-23 ▪ Supporting organizing and rights-based advocacy of people who use drugs
Harm reduction progress	Nascent, one service (pilot) opened during the implementation period in 2018 – kick-starter, to transit to accelerator
Funding tendencies	Increasing from the Global Fund (US$32,000 in 2018-2020 and projected US$4.7 million in 2021-2023), reducing from PEPFAR

INCREASING NEEDS BUT FEW ACTIONS BEFORE 2017

Globally, Mozambique has the sixth highest HIV levels with 12.6% of adults living with HIV and is one of 30 countries with the highest TB burden globally. In this context, the country finds it challenging to prioritize HIV among key populations, despite evidence of increased drug use and injection.

Since 2010, people who inject drugs (PWID) have been identified as a key population in the national HIV response[13] but as of February 2018 there were still no harm reduction interventions active in the country. In 2013-2014, a PEPFAR-funded study found the levels of HIV, HBV and HCV prevalence among PWID at 44.9%, 32.8% and 38.3% respectively[14]. The study showed that people "would rather rent, share or borrow injection equipment at shooting galleries than purchase them due to stigma, fear of criminalization, … costs". The barriers to health and social services included placing drug use and dependence under mental health services, as users, unlike health professionals, did not perceive their own drug use as a mental illness[15]. The drug use problem has become so visible in one neighbourhood of Maputo, Mafalala, that the local community organization, ACAM (Associação Comunitária Ambiente da Mafalala), identified drugs as the most urgent issue to address for the community. Law 3/97, which lays out legislative approaches to drug use and trafficking, punishes drug use with imprisonment, does not differentiate between users and traffickers, and does not authorize harm reduction.

[13] PEPFAR. Mozambique COP 2020

[14] Semá Baltazar C, et al. Prevalence and risk factors associated with HIV/hepatitis B and HIV/hepatitis C co-infections among people who inject drugs in Mozambique. BMC Public Health. 2020 Jun 3;20(1):851.

[15] Dengo-Baloi L, et al. Access to and use of health and social services among people who inject drugs in two urban areas of Mozambique, 2014: qualitative results from a formative assessment. BMC Public Health. 20(1):975.

From 2014-17, the country saw limited action in follow up to the PEPFAR study. In September 2016, MSF conducted an assessment on harm reduction feasibility in the country. Eventually in April 2018, in partnership with a local organisation, UNIDOS (Rede Nacional Sobre Droga & HIV/SIDA), MSF opened the first drop-in centre[16].

PITCH APPROACH

Frontline AIDS does not have a founding partner in Mozambique. Under PITCH Frontline AIDS[17], together with Aidsfonds, decided to collaborate two organizations already involved in drug issues and MSF efforts, ACAM and UNIDOS. Their goal was to "change policies, practices, and minds towards people who use drugs", as one project implementer recounted. The four objectives included for harm reduction included:

(1) Initiating drug policy dialogue between Maputo and national authorities and communities, preparing ground for partial legal decriminalization of Drug Law 3/97;

(2) Getting government authorization of and support for harm reduction;

(3) Mobilizing political, operational and financial support for harm reduction scale-up;

(4) Supporting organizing and rights advocacy of people who use drugs.

PITCH funding was flexible and focused on advocacy – it did not fund services. It targeted a number of audiences, including the National AIDS Commission, Ministry of Health, the Parliament, the police and the Drug Control Cabinet, as well as Maputo city authorities.

At the same time, PITCH worked with affected community groups on the rights of other populations: sex workers, adolescent girls and young women and sexual minorities. Reportedly however, PITCH activities were largely planned in siloes, with limited strategies across populations.

Only in 2018, direct coordination and management support was engaged to support PITCH partners and capacity challenges on the ground.

CHANGES ACHIEVED

1. Enabling creation of MozPUD with a strong focus on rights

With PITCH support, supporting leadership and organizing of people who use drugs was prioritized. The ACAM-supported PWUD group initiated registration proceedings, calling themselves REAJUD. In parallel, people working with UNIDOS formed an organization called Rede Solidaria. In August 2019, MozPUD was established, bringing together REAJUD and Rede Solidaria. Today MozPUD has a five-person board, including two women. In 2020, the network established a group in Beira. Just in the focus group alone for this assessment, there were 10 people from MozPUD connected online to share their thoughts. MozPUD is expected to be fully registered in December 2020.

While in the MozPUD group interviewed no one is taking OAT, the expansion of this service is a major MozPUD goal. The group members continue to be interlinked with both UNIDOS and ACAM, with both

[16] MSF. Mozambique: International Activity Report 2018.
[17] At the time, the organization was called the International HIV/AIDS Alliance and changed its name in 2019, however, for clarity we use the name Frontline AIDS throughout the case study.

organizations serving as financial agents for MozPUD – ACAM funding office space, while UNIDOS channelling allowances and providing training opportunities. MozPUD is therefore not a direct partner for PITCH.

MozPUD embraced Frontline AIDS-developed REAct as a human rights tool for registering issues of harassment and abuse. The group would like to expand this in the future - "*We need to follow-up on the cases that we are observing. If we had paralegals, they would do more than register cases. They'd ensure that these cases are addressed*." However, it was not clear if such work would be funded through the Global Fund's country grant and the group did not know how to make that happen. During this assessment process, it was noted that Frontline AIDS helped MozPUD to access technical assistance funded directly by the Global Fund to better understand donor related processes and opportunities in the country.

While this MozPUD is still new with limited organizational and advocacy experience, the group increasingly participates in shaping the country's harm reduction agenda. They have been the driving force to increase action on overdose, arguing that replacing injectable naloxone with nasal naloxone would improve its acceptability in the community.

> *Originally, there was no distinction between providers of services and PWUD. Harm reduction groups would represent people using drugs. MozPUD is yet to be represented in CCM. (National partner)*

> *Creating MozPUD brought different dynamics to advocacy campaigns, putting users as the people with first-hand experience, with their own voice. (Focus group with MozPUD members)*

2. Authorization of harm reduction and effective drug treatment

> *It was the first time I heard of harm reduction – the name and the issues of harm reduction, how the police can help to see drug consumers as human beings and support improved human rights. (Dr Justina Cumbe, Superintendant of the Mozambique Police)*

Legally harm reduction is in a grey area because of criminalization of drug use and possession in Law 3/97. In May 2018, the Maputo City Director of the Central Cabinet for the Prevention and Combatting of Drugs (CCPCD) authorized the first harm reduction site in Maputo City[18]. On the same day, a MoU was signed between the City Governor, CCPCD's Maputo City Director, Family Health International, MSF and UNIDOS to open the Mafalala community (drop-in) centre. This was the result of persistent advocacy with city officials, the Ministry of Health, the police, and extensive consultations with local communities, which was initially started by MSF. ACAM and UNIDOS brought additional evidence to the table after two HIV and HCV testing campaigns in 2017. Signing the second MoU to extend the community centre for another two years has been significantly easier in 2020.

This authorized community centre runs in partnership between UNIDOS and MSF and is funded from non-PITCH sources. It has been critical in demonstrating the feasibility of harm reduction approaches.

[18] Draft PITCH End of Project Evaluation Report: Harvested Outcomes, November 2020.

The centre provides needles and syringes, HIV, TB and hepatitis C testing and treatment, and already in its first year was seeing around 100 visitors a day. By October 2020, 2150 people had utilized the centre in Maputo alone. Specific hours at the centre are allocated for services to women who use drugs.

Opioid agonist therapy with methadone was introduced by UNIDOS and MSF in December 2019. However, according to national partners, an official from the Ministry of Health stopped it in January 2020. This happened reportedly after seeing the community centre and perhaps perceiving it as too well-funded for a marginalized group focused centre in the context of an under-resourced health system. It was PITCH partners who alerted the National AIDS Council about the OAT interruption. The Council denounced the interruption, and OAT was reinstated the following month.

This 'incident' exposes broader challenges with how the health system addresses people who use drugs and drug dependence. Traditionally, drug treatment has always been dealt with as part of mental health, which has undergone little reform and has received limited attention from the global community. Engaging HIV leadership has helped to protect OAT.

3. Mobilizing political, operational and financial support for harm reduction scale-up

In 2019, the Ministry of Health initiated the development of a national harm reduction plan. This was a result of ACAM and UNIDOS engagement and advocacy within Technical Working Groups on key populations at the Ministry of Health and National AIDS Council. In parallel, the development of a new funding request to the Global Fund started. ACAM and UNIDOS, both part of the Technical Working Group of Key populations at the Ministry of Health, saw this as an opportunity, encouraged by Frontline AIDS technical lead on harm reduction[19].

Frontline AIDS engaged a consultant team to support PITCH partners on harm reduction but also other populations in the process of the Global Fund process. One consultant developed a costed plan for expansion of harm reduction and supported ACAM and UNIDOS to effectively use their membership in the CCM, to ensure a significant budget for harm reduction.

The Global Fund approved the country's grant request 2021-2023, which included approximately US$4.7 million for harm reduction (in comparison with US$32,000 in the current grant)[20]. The Global Fund grant will support the Maputo site and open three additional sites in other parts of the country. The National Harm Reduction Plan for 2021-2023, a comprehensive, 80+ page document, is being finalized and is expected to be co-signed by the MoH and WHO by the end of 2020.

4. Opening drug policy debate and ground for revision of Drug Law 3/97

Already in 2017, ACAM and UNIDOS conducted a series of drug policy discussions not only with the health authorities and the police but also with local communities, the Mapuche Catholic Archbishop, youth associations and members of the Rastafari Movement. They recall this process as breaking taboos: "*The government of Mozambique never previously publicly discussed drugs, drug use and assisting these communities. Talking about drugs was seen as promoting drug use, and people in high positions couldn't be seen politically as discussing such issues*." Like services, knowledge of harm reduction was only emerging.

At the first high-level national meeting with authorities under the PITCH project, NAC's ED passionately confirmed that people who use drugs are a key population in the national AIDS policy and gave new

[19] Bwangyuan Wang was the technical lead on harm reduction at Frontline AIDS 2016-2019.
[20] This amount may have changed recently during ongoing grant negotiations between the country and the Global Fund. Unfortunately, FDC, the principal recipient for the grant from the Global Fund, have not agreed to interview.

energy and legitimacy to ACAM and UNIDOS advocacy efforts. A month later, the first international event engaging law enforcement and harm reduction took place and created unique opportunities for experience exchange with the police from Uganda, Tanzania, Kenya, the Netherlands and the UK. Dr Justina Cumbe, Superintendant of the Mozambique Police confirmed this peer exchange as a critical step towards understanding the issues of harm reduction. A PITCH national partner said that "*this experience paved the way for some concrete cooperation [with the police] on harm reduction*".

Another implementer pointed out that government discussions with Frontline AIDS at the 2018 East African Harm Reduction Conference were instrumental in moving policy forward. After conference discussions the Director-General of the Central Office of Prevention and Combatting Drugs privately told fellow delegation members that he saw the need to "fix the law" and committed to push reforms. In 2019 this same DG delivered comments at the UN Commission on Narcotic Drugs on behalf of Mozambique making the case for decriminalization and reforming of Drug Law 3/97 (see box). The draft amendment has been prepared, though its current status is unclear, including whether the Ministry of Justice has been involved in the discussions so far. Moreover, reportedly the DG has been replaced.

CENTRAL OFFICE OF PREVENTION AND COMBATING DRUGS MAKES THE CASE FOR CHANGING LAW NO.3/97

Given the complexity of the work that must be done to have a law on drugs more adjusted to the current socioeconomic reality of our country, the GCPCD prepared the draft of the proposal to revise Law no. 3/97, of 13 March, in which several article amendments are proposed. … Therefore, because we think it is a fair position, balanced according to our country's Constitution principles, we assume that the consumption of illicit drugs must be decriminalized.

From the statement of the Republic of Mozambique at the UN Commission on Narcotic Drugs, 2009[21]

UNITE, a global network of parliamentarians on HIV, TB and hepatitis C, in consultation with PITCH, invited Mozambique MPs to a side meeting at the International Harm Reduction Conference in Porto to hear about the Portuguese decriminalization experience. Following these developments, ACAM and UNIDOS, in collaboration with MozPUD, organized meetings at the National Assembly 3rd Committee on HIV and Gender to discuss the need for drug reform. According to national partners, at the end of the meeting, the Committee committed to review amendments to Law 3/97 in 2020-2021.

BOX: GIVING A FACE TO THE DRUG PROBLEM - BREAKING TABOOS AND PERCEPTIONS IN THE PARLIAMENT

MozPUD's Executive Director Stelio personally played a role in changing people's perspectives. He told Parliamentarians "We are the people who use drugs, we are your children, sisters, and brothers. We need your support to change law 3/97." The Parliamentarians couldn't believe that Stelio was actually a drug user and willing to openly talk about it. Stelio explained that "Yes, I do use drugs, but fortunately I have been supported by my family, I was not thrown out as many are." He shared experience on police harassment, including police arresting people who come for needle exchange. Stelio gave a face to the issue, and also pointed out what the Parliamentarians could do, which was change the law.

From an interview with national partner

[21] Translation from the Portuguese language, as shared by ACAM.

FACTORS FOR SUCCESS, GAPS AND OPPORTUNITIES

1. Direct support and external technical expertise

In Mozambique, Frontline AIDS was uniquely positioned to assist country partners, as the current Frontline AIDS technical lead, Ancella Voets, had served as MSF's consultant in 2016. She developed the first needs assessment in the country, paving the way for harm reduction efforts. Ancella being well aware of the needs and the actors, used this knowledge to strategically plan programming and work with the Global Fund engagement team at Frontline AIDS, particularly for the new country's funding request to the Global Fund. "*The Global Fund grant [with significant funding for harm reduction] would not have happened without Ancella*", Daniel Wolfe from Open Society Foundations commented. Other Frontline AIDS staff are also often mentioned as supportive voices.

Frontline AIDS support has been instrumental in helping to mediate and coordinate between ACAM and UNIDOS, organizations with different expertise and approaches. As one interviewee noted they "were meeting only under the planning of PITCH", particularly at the initial phases and would have their own separate plans within the project, often "compete, rather collaborate". Being exposed to other country examples where different partners have managed to agree on a joint plan despite differing approaches has been an important element in the increased alliance between these two PITCH partners.

2. Increased connections and greater solidarity

PITCH created opportunities for interaction among community groups, supported by PITCH, within Mozambique and partnerships with peers and networks from other countries.

- UNIDOS supported work led by LAMBDA, Association for Sexual Minority Rights, to successfully introduce dolutegravir in the country, as well as initiate PrEP.
- MozPUD applied to join the National Sex Worker Platform. In 2020, MozPUD participated in a joint civil society declaration led by sex workers expressing concerns over police harassment of sex workers and people who use drugs during COVID-19.
- In September 2020, UNIDOS signed an MOU with the Portuguese Porto-based harm reduction organization, whom they met during the International Harm Reduction Conference.

3. Remaining gaps in organizational and technical capacity gaps

> *Here [in Mozambique] you have too few people with knowledge in harm reduction, their knowledge is not comprehensive. (National partner)*

Work to develop the country's harm reduction capacity is far from over. Several actors highlighted that both harm reduction values and practices are new in the country, and that organizations doing this work are quite underdeveloped. This is particularly daunting given that the country is supposed to start harm reduction scale up. PITCH partners are prioritizing their harm reduction technical knowledge. They are aware of the Harm Reduction Academy - however, only one member participated to date given the cost and limited access and expressed the critical need for more accessible learning options. Partners also noted that it is important for them to become conversant in English, so that they can better interact regionally and globally.

Building organizational development capacity was pointed out as a need, though has not been a PITCH priority. Only in May 2020, were conversations started locally on sustainability and organizational/financial needs going forward. As a next step, UNIDOS is planning to develop their first ever strategic plan for the next 5 years and a website. MozPUD is still working to finalize their registration, and did not share sustainability priorities in their interview. One interviewee expressed concern about partners capacity to financially manage and monitor financial accounts and the related reporting needed in order to fundraise.

4. Linking with existing funding opportunities

Because of its high HIV burden and low-income classification, Mozambique benefits from major HIV funding: US$496 million over the next three years from the Global Fund[22] and projected US$419 million for 2020 from PEPFAR[23]. Within this commitment, the Global Fund will increase its funding for services.

More opportunities with the expansion of harm reduction services might lie with PEPFAR, if it was convinced to get engaged – often Pepfar is willing to pay for significant technical assistance attached to programmatic plans. However, so far only a tiny fraction of PEPFAR funding is focused on people who inject and use non-injected drugs - just US$143,079 in 2019 and US$24,771 in 2020[24, 25] in comparison, US$14 million is planned for abstinence and be faithful programming among youth in 2020. It remains to be seen, however, as one interviewee said, if the PITCH partners and MozPUD will have sufficient capacity to advocate for increased support and become an active part of these opportunities. An important Frontline AIDS role is to make sure this capacity is built.

5. Drug policy challenges and opportunities

PITCH partners are uncertain if the new Global Fund support will fund work to sensitize local authorities in new localities and continue decriminalization reform efforts. Legal reform and sensitization efforts are equally important. MozPUD members related a story of a man who uses drugs, recently beaten up by the police, when he refused to give a bribe. A TV story highlighted this example as successful police work, depicting the man as a major criminal with possession of a syringe as proof of criminality. MozPUD members believe that a lot of work still needs to be done with the police and changing societal perceptions on drug use and drug users. Similarly, other partners agreed that advocacy will be needed also to ensure continuation of NSP and OAT.

> *We should not take the pilot of opioid substitution therapy as granted. Some people who are powerful at the Ministry of Health, Parliament or the Police can still revert this decision. (National partner)*

[22] The Global Fund. Data Explorer. Mozambique allocation 2020-2022.
[23] The exact amounts are approved annually. The number is for 2020, based on PEPFAR. Mozambique COP 2020.
[24] amfAR. https://copsdata.amfar.org/s/Mozambique
[25] PEPFAR. Mozambique COP 2020.

NIGERIA: IMPORTANCE OF WORKING TOGETHER

Implementing partners	YouthRise Nigeria Drug Harm Reduction Network (DRAHN) Community Intervention Network on Drugs (CIND)
Frontline AIDS Programme	PITCH (2016-2020) IHRP (2019-2020)
Amount of budget	Total: US$232,000 including -US$40,000 from IHRP (including international TA) & -US$192,000 from PITCH (for harm reduction) ▪ 2017: 17,000 ▪ 2018: 27,000 ▪ 2019: 65,000 ▪ 2020: 83,000
Estimated number of people who use drugs	376,000 high-risk drug users including 80,000-200,000 people who inject drugs [26, 27] (pharmaceutical opioids, cocaine and heroin)
Advocacy and capacity building priorities	• Initiating drug policy debate for partial legal decriminalization • Illustrating the role that CSOs can play in blocking punitive policies against PWUD • Getting authorization of and support for harm reduction • Supporting organizing and rights work of PWUD
Harm reduction progress	Nascent, three services (pilots in Abia, Gombe & Oyo States) opened during the implementation period – kick-starter
Funding tendencies	Increasing from the Global Fund; PEPFAR in 2019: US$252,998

CONTEXT

Nigeria is the largest African economy with a relatively low prevalence of HIV in the general population (1.5%). People who inject drugs account for up to 9% of new HIV infections. HIV prevalence amongst PWID averages 3.4%, ranging from 1.2% in Lagos to 7% in Kano, with females having 5-fold higher rates than males.[28] Prevalence amidst female sex workers who inject drugs is even higher – at 43%.[29] Just 12% of people using 'high-risk' drugs reported being referred for ART[30,31]. Opioid substitution therapy is not available in Nigeria (piloting projected in 2021). In a major step forward, in September 2020 needle and syringe programmes commenced as a pilot study in three States – Abia, Gombe and Oyo, and are projected to expand in 2021-2023 with the Global Fund's grant, partnering with PEPFAR.

The Nigerian Government has ranked fighting drugs as a top political and security priority. The country has one of the harshest drug-related penalty regimes globally, calling for 15-25 years in prison for drug use and possession[32]. The West African Commission on Drugs, a high-profile group initiated by Kofi

[26] UNODC. Drug use in Nigeria, 2018.
[27] UNAIDS Key population Atlas, accessed on 15 November 2020.
[28] National HIV/AIDS & STIs Control Programme, Federal Ministry of Health, Nigeria. Integrated Biological And Behavioural Surveillance Survey (IBBSS) 2014 November 2015
[29] NACA (2017) 'National Strategic Framework on HIV and AIDS: 2017 -2021'
[30] National Agency for the Control of AIDS (NACA). National Guidelines for Implementation of HIV Prevention Programmes for People who Inject Drugs in Nigeria, 2020.
[31] National HIV/AIDS & STIs Control Programme, Federal Ministry of Health, Nigeria. Integrated Biological And Behavioural Surveillance Survey (IBBSS) 2014 November 2015.
[32] IDPC, West Africa Commission on Drugs. Drug laws in West Africa: A review and summary, November 2017

Annan, and chaired by the former Nigerian President, wrote to the Nigerian parliament urging decriminalization of drug use and possession.[33]

Prior to PITCH, PWID were already listed as a key population in the national HIV program. The 2014 HIV prevalence study concluded that "PWID … may no longer be justifiably grouped with the others as "most at risk populations" for HIV." Further the National Drug Control Master Plan 2015-2019 (NDCMP)[34] outlined the "twin issue of drugs and HIV and AIDS" and committed to the National Agency for the Control of AIDS (NACA) and the Federal Ministry of Health (FMoH) "establishing models of comprehensive, accessible, affordable and evidence-based HIV prevention, treatment and care services for drug users, with a focus on PWID. Guidelines and toolkits on HIV prevention, treatment and care services for PWID will be developed. Service providers will also receive appropriate training".

Notably, the NDCMP sets out plans for establishing 'multi-sectoral coordinating platforms / committees [on HIV and drugs] <..> at national and subnational levels', 'advocacy tools to coordinate HIV and TB activities for drug users with a focus of PWID' and an increase in the number of drug user networks established. In 2015 NACA began working with the United Nations Office on Drugs and Crime (UNODC) on a draft national HIV response strategy to target people who inject drugs. The National Strategic Framework on HIV and AIDS 2017-2021 identifies providing people who inject drugs with harm reduction services including needle and syringe programmes.

APPROACH

Frontline AIDS provided both IHRP and PITCH support in Nigeria. Frontline AIDS did not prioritize efforts in Nigeria solely because of harm reduction needs, but rather the overall importance of Nigeria for HIV – most populous African country, receiving one of the largest Global Fund HIV grants.

Given that Frontline AIDS had no founding partners in Nigeria, it needed to develop a deeper understanding of the context and identify partners. Through a joint scoping exercise, Frontline AIDS and Aidsfonds identified YouthRISE Nigeria, DRAHN and CIND as potential partners. YouthRISE Nigeria was a natural partner as the organization had a good reputation in harm reduction, partly thanks to their ground-breaking report on drug policy in 2015 in Nigeria[35] and an international Red Ribbon Award in 2016. YouthRISE Nigeria received both IHRP and PITCH funding. The organization's Project Manager, Adeolu Ogunrombi is part of the high-profile West African Drug Policy Commission. DRAHN and CIND were selected for their presence in communities of PWUD across Nigeria and received PITCH funding.

Armed conflict in the country including Boko Haram activities delayed implementation to May 2017. Like in other countries, planning included a country exercise defining theory of change, community strengthening, and opportunities for civil society and key decision makers to be exposed to harm reduction expertise abroad.

> *The Global Fund process always focused exclusively on engaging only key populations to the detriment of a collective effort –sometimes that makes other CSOs look like enemies of key populations. What I saw in Frontline AIDS and PITCH struck a balance in connecting everyone on the issues of PWUD. (National partner)*

[33] West Africa Commission on Drugs. Not just in transit. Drugs, the State and Society in West Africa, June 2014.
[34] National Coordinating Unit (for Inter-Ministerial Committee on Drug Control) – NDLEA. National Drug Control Master Plan 2015-2019, June 2015.
[35] YouthRISE Nigeria, Civil Society on the Health & Rights of Vulnerable Women & Girls in Nigeria & OSIWA. We are people: The Unintended Consequences of the Nigerian Drug Law on the Health and Human Rights of Young People Who Use Drugs, 2015.

STEPS TOWARDS IMPACT

1. Preventing increased criminalization of people who use drugs

Sentences handed out for drug use by judges have historically been confined to payment of minimal fines, caution, and minimal prison terms. In 2017, a bill stipulating 15 to 25 years prison term for drug use and possession was introduced. Over three months, YouthRISE Nigeria and other PITCH partners waged a social media campaign to engage with policymakers and the Office of the President on the possible effects of this bill. After being alerted by YouthRISE Nigeria, WACD Chair and former Nigerian President Olusegun Obasanjo wrote a letter to the Nigerian Parliament and the Office of the President expressing his concern. The campaign was ultimately successful and the bill was not passed, allowing judges to continue to use their discretion in sentencing drug use.

2. Technical working group on drug reduction within Federal Ministry of Health

The Technical Working Group was formed after the Minister for Health approved a WHO initiated harm reduction concept note, which included the forming of a national level working group. The TWG was approved in 2018 and is hosted by the Federal Ministry of Health, with funding from YouthRISE (IHRP funds). The TWG is chaired by the Department of Drug Reduction, with membership including FMoH, UNODC, WHO, NACA, CIND, YouthRISE, DRAHN, the STI Control Program, police, Society for Family Health (SFH), and religious and cultural leaders. *"PWUD are part of the working group and attend its meetings. They are mobilized by DRAHN to participate in the TWG activities."* - Dr. Salaudeen of FMoH. The TWG provides coordination for preparing the ground for harm reduction work in Nigeria.

> *If you speak about harm reduction, there's an understanding that you're promoting drug use. The interest by the government is a breakthrough (it involved even religious leaders and the media) –this is a major achievement. (Dr Salaudeen, FMoH)*

3. First needle exchanges capacitated and operational

> *The minister of health in Nigeria consenting to a concept note laying the foundation for implementing comprehensive harm reduction is a great milestone, and an essential rubric for approaching drug use from a public health perspective. (Anthony Nkwocha, PITCH Nigeria Country Focal point)*

In 2019, in consultation with the TWG, Frontline AIDS produced a NSP Training Curriculum for harm reduction practitioners. The NSP Training Curriculum was designed as a 4-day Training Course consisting of a 3-day course on NSP service delivery and a 1-day course on opioid overdose and naloxone. While the first training was convened and paid for by SFH using Global Fund grant support, Frontline AIDS paid for the developer and trainer (Mat Southwell[36]). The NSP Training Curriculum includes a full set of trainer tools (presentations, trainers notes and handouts), therefore it can be replicated easily in the future.

In developing the curriculum, the Frontline AIDS consultant extensively consulted people who use drugs, service providers, health officials and authorities, and went out to the drug scene to adapt the tool to street realities. The manual addresses specific needs and approaches to serve women who use drugs and sex workers, how managers and outreach workers can help ensure client safety in drug gang

[36] In addition to more than 25 years of experience in developing services, Mat Southwell has been involved in the development of rights movement of people who use drugs. He is currently the Project Manager at European Network of People who Use Drugs.

areas, and how to sensitize law enforcement. As a global leader of the PWUD rights movement, Mat also helped to navigate multiple community-based groups and empower legitimate leaders of people with significant drug use and drug injecting experience.

In parallel, the national stakeholders, with active involvement of PITCH partners, agreed on the peer-led service delivery model of HIV prevention. This model was adopted in the first National Guidelines for Implementation of HIV Prevention Programmes for People who Inject Drugs, approved in September 2020[37]. Having these two parallel processes was a challenge but enabled the PITCH consultant to expose national stakeholders early on to benefits of peer practices, which have also been reinforced by the Global Fund harm reduction focal point in Geneva.

> *The Global Fund supported a pilot study that looked at how best to implement harm reduction practices in Nigeria. We learnt that having networks of PWUD in the conceptualization, design and programming, is key to the successful implementation of harm reduction programs. We have included these practices in Nigeria. (Godpower Omoregie, HIV and TB Practice Lead, Society For Family Health – SFH, one of the principal recipients for the national Global Fund Grant 2018- 2020).*

The rollout plan was drafted by the Frontline AIDS consultant who in early 2020 co-facilitated a series of workshops bringing together FMoH leadership, the drug enforcement agency, civil society, and PWUD. These workshops served as a bonding and learning experience for critical officials from health and law enforcement sides. In late September 2020, the ministry of health authorized operations in three harm reduction sites mentioned above.

FACTORS OF SUCCESS

> *Early this year, as we were moving from State to State, we became a 'rockband', a tight group. I was seeing these high-level heads of drug control, along with people who use drugs in the same meeting. That was a stigma-busting process. (Mat Southwell, Frontline AIDS consultant in Nigeria)*

1. Relationships and linkages created across partners and initiatives

In Nigeria, a number of global partners were interested in moving the harm reduction agenda forward. These partners included the Global Fund and UNODC funded under a major European Union project. As shown in the context section, government documents laid out a strong framework for harm reduction - however, it was clear from the beginning that Nigerian government support from various offices and leaders was required to successfully move forward.

In 2019 Frontline AIDS HIV Technical lead (Harm Reduction) travelled to Nigeria with Palani Narayanan, a Senior Advisor for Drug Use and Community Responses at the Global Fund to strategize on the NSP pilot programme. As part of this joint exercise, it became clear that national partners needed to be exposed to peers from other countries. As follow up, the Frontline AIDS team working with the Global Fund supported a technical visit of civil society, FMoH and law enforcement agencies to Kenya. The visit inspired Nigerian national actors by highlighting real life examples of people in need and life-saving services provided. During this trip, they agreed on next steps to be done upon return home.

[37] National Agency for the Control of AIDS (NACA). National Guidelines for Implementation of HIV Prevention Programmes for People who Inject Drugs in Nigeria, 2020.

At the same time, national partners, like YouthRISE Nigeria, progressively sought to build broader partnerships within civil society to call for action. In partnership with PEPFAR-funded Heartland Alliance and enda Santé, they generated additional evidence and published a joint position arguing for harm reduction[38].

2. Flexibility of funding

Though Nigeria was not initially considered for IHRP funding, given capacity building needs Frontline AIDS reallocated IHRP funds to Nigeria. Frontline AIDS project advisors allowed partners to determine where and how to use the funds. Many partners and grantees noted how impactful these flexible funds have been to moving things forward in the country.

3. Investment in fundraising capacity

Frontline AIDS supported YouthRise Nigeria's capacity to write grant proposals. Together for over two years they worked on a proposal to Elton John AIDS Foundation (EJAF). The proposal was not successful - however, "*we left them with a solid costed workplan which they can use to mobilize resources independently of Frontline AIDS*", Frontline AIDS point person.

CHALLENGES AND OPPORTUNITIES FOR THE FUTURE

1. Delays and friction between main stakeholders

While linkages and the TWG have been among the successes and enabling factors of work in the country, there were also many challenges. These included complex relationships and power dynamics among multiple interest groups and problems with effective process management. These issues contributed to the delays of opening the NSPs in 2020.

Lack of solid relationships between FMoH and the Global Fund PR (SFH) "caused friction and affected momentum of activities". SFH together with the Global Fund's Secretariat agreed on prioritizing the provinces for piloting that have the highest HIV prevalence. However this was not agreed on with the TWG. SFH proceeded with implementation without alignment with other partners, and without getting needed approval from the FMoH ethics committee.

Government officials found out about this situation at a TWG meeting, once the NSP pilots started. The situation could have easily grown into a major conflict, but was averted by the efforts of a WHO consultant who was formerly part of YouthRISE Nigeria, who provided mediation support.

In the next Global Fund cycle Family Health International (FHI) will take over the PRship for key population programming from SFH. Frontline AIDS partners will need to build connections with FHI, an organization with limited exposure so far to the issues of people who use drugs and drug policy.

2. Limited efforts on decriminalization of PWUD

Despite HIV paving the way for harm reduction and involvement of people who use drugs in national drug policy, drugs still remain largely seen as an issue linked to drug trafficking and crime. The successful campaign to stop the sentencing bill was not followed up by systemic work to remove the 20-25 year sentencing for simple drug use. These were missed opportunities.

[38] YouthRISE Nigeria. Addressing Barriers to Effective HIV Prevention and Service Delivery Among People Who Inject Drugs in Nigeria. Policy Brief, 2018

The President launched a consultation on drug issues and at least one Frontline AIDS partner participated, but it is unclear how well or forcefully they argued for decriminalization. The Federal Minister of Health until May 2019 was a progressive, pro-rights health advocate who had been sensitized to approve the concept of harm reduction. Some partners saw him as a potential ally for decriminalization. The new health minister who was not part of the initial dialogues on harm reduction, has not been as supportive. The efforts for decriminalisation require focused advocacy and prioritization by Frontline AIDS partners if Nigeria is to at least soften their worst drug-related laws.

3. Gaps in services despite planned scale up

The Global Fund will continue support for the three pilot NSP sites in 2021-2023. In 2022, according to the country's request to the Global Fund, Nigeria will add three additional sites in high burden states where PEPFAR partners already lead key population programming, but do not yet reach PWID/PWUD.

While the new PR's vision and assessment of the needs is yet to be seen, current partners envision a need for technical support and advice for NSPs and OAT operational research, particularly at the service level. Technical knowledge within the country remains limited. The status of the pilots is officially categorized as operational research, and the future scale up of harm reduction will largely depend on the success and quality of the first sites.

Unfortunately, expansion plans currently do not include Abuja where HIV prevalence is lower and where YouthRISE Nigeria has already started services for PWUD, focusing on women. Not having service in the capital city will limit visibility of harm reduction and peer-led models among federal officials. There is interest from the Global Fund to leverage investment for harm reduction from PEPFAR.

4. Need for strengthened civil society advocacy

In order to sustain country gains, over the next 5-10 years, civil society and partners will have to lead advocacy for progressive implementation of harm reduction, partial or full decriminalization, and domestic funding for harm reduction. The country has supportive partners from WHO and potentially soon will have a UNODC focal point for harm reduction. There are also supportive senior members within FMoH. INPUD is planning to support DHRAN's work on organizing of people who use drugs and might help to confront some challenges in DHRAN and the local movement of people who use drugs. These challenges include how to balance their goals of drug free Nigeria with the rights of people who use drugs, how to overcome deception of those claiming to be PWUD/PWID, when they aren't, and how to provide opportunities for leaders conducting outreach to attend meetings and represent voices of people who use drugs.

Despite the positive developments, there are gaps. Future funding sources for advocacy of harm reduction and TWG are yet to be identified. Unfortunately, YouthRISE Nigeria, Frontline AIDS primary partner, has lost its key strategist and voice for harm reduction, Adeolu Adebiyi. He is now working for WHO Nigeria. While the organization has filled the staff position, the YouthRISE Nigeria team would benefit from additional guidance in strategic and political planning, as well as ramped up technical advice. As a youth organization, YouthRISE Nigeria could become a potential incubator of a new generation of leaders successfully taking harm reduction and drug policy into Nigeria's future – but they need guidance and financial support to do so.

ANNEX B : RESPONDENT LIST

India

- Kunal Kishore, Associate Director, Alliance India
- Prashant Sharma, Sikkim Drug Users Forum
- Dr. Ravindra Rao, National Drug Dependence Treatment Centre / WHO Collaborating Centre on Substance Abuse, All India Institute of Medical Sciences
- *Nasreen & Radha Rani, peer educators at Bharatiya Parivardhan Sansthan & Bhagwati Prasad, Alliance India
- Sobhana Sorokhaibam, Nirvana Foundation

Mozambique

- Gabriel DeBarros, PITCH Country Focal Point
- Stelio, Amarildo, Flavio, Sofia, Celina, and at least two more members of MozPUD
- *Manuel Condula, Coordinator; Belarmino Langa, Advocacy Officer; and Cidio Generoso, Program Officer, UNIDOS
- *Job Mutombene, Executive Director; Moiseis Cristiano Tavete, M&E Officer; & Etna Braz, Social Action Officer, ACAM
- Dr Senior Superintendent Maria Justina Eduardo Cumbe, Head of Planning and Projects, Mozambique Republic Policy

Myanmar

- Yan Win Soe, PITCH Country Focal Point, Dr Nwe Ni Myint, Director of Programmes & Dr Ye Min Aung, lead on IHRP, Alliance Myanmar Mahamate
- *John Mang, Project manager for CSF – Charity Service for Friends
- Dr Nanda Myo Aung Wan, Program Manager at Drug Dependency Treatment and Research Unit, Ministry of Health and Sports
- *Ko Sai Aung Kham, a Chairperson, NDNM - National Drug User Network in Myanmar
- Nu Nu Lwin, Advocacy and Communications Officer, MDM - Médecins du Monde
- Zin Ko Ko Lynn, National Project Coordinator (Drug Abuse Prevention and Treatment of Drug Dependence, UNODC Country Officer

Nigeria

- Anthony Nkwocha, PITCH Country Focal Point
- Adeolu, formerly YouthRISE Nigeria, currently WHO Nigeria
- Seyi Kehinde, Programme Officer, YouthRISE Nigeria
- Akpan Aniedi, Chairperson, DRAHN
- Nonso Maduka, Secretary, CIND
- Dr. Salaudeen Olawale Jimoh, Director in charge of Drug Demand Reduction/ Harm Reduction, Federal Ministry of Health
- Dr Godpower Omoregie, HIV & TB Lead, SFH - Society for Family Health (Principal Recipient for the Global Fund grant for key populations until 2021)
- Bryan Morris, Portfolio Manager for Nigeria, Global Fund
- Mat Southwell, freelance consultant engaged by Frontline AIDS in Nigeria

Senegal

- Ousseynou Badio, IHPR programme manager, ANCS
- Moustapha Mbodj, PWUD group SEV
- Matar Diop, Coordinator Intersectoral Group on Drugs, Ministry of Interior
- Cheikh Diop, Executive Director, Centre Jacques Chirac
- Mama Seyni Dieye, Drug Demand Reduction Officer, UNODC Country Office

Global partners

- Ann Fordham, Executive Director, IDPC – International Drug Policy Consortium
- Daniel Wolfe, Open Society Foundations
- Palani Narayanan, Community, Rights and Gender Department, Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
- Ruth Birgin, WHRIN - Women and Harm Reduction International Network

Frontline AIDS

- Revati Chawla, IHRP, Lead: Programmes
- Sheila Crespo, PITCH lead for Myanmar, Nigeria, Mozambique & supports IHRP
- Fionnuala Murphy, Head: Influence
- David Clark, Head Programmes

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