INPUD International Network *of* People *who* Use Drugs

Briefing Note:
Global AIDS Strategy 2021 - 2026

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The New Global AIDS Strategy (and why we should care)

At its 47th meeting, the UNAIDS Programme Coordinating Board (PCB) adopted a new strategy to end the AIDS epidemic as a public health threat by 2030. The PCB is made of 22 Member States, elected from among the Member States of the Cosponsoring Organizations. Five non-governmental organizations, three from developing countries and two from developed or transitioning countries, are also invited to participate in meetings of the PCB but without the right to take part in the formal decision-making process and without the right to vote.

The UNAIDS 2016–2021 Strategy is one of the first in the United Nations system to be aligned with the Sustainable Development Goals, which sets the framework for global development policy over the next 15 years. The new global AIDS strategy will serve as a road map for the whole world, guiding key stakeholders to ensure effective country-led AIDS responses.

The strategy was developed through a data-driven and consultative process involving the UNAIDS staff, the Cosponsors, civil society, people living with HIV and key populations, young people, faith institutions, ministers of health, finance, and gender and parliamentarians, scientists, donors, and the private sector.

With new global targets for 2025 and resource needs estimates, the new strategy will also shape the next United Nations General Assembly High-Level Meeting on Ending AIDS (HLM) and its Political Declaration, to be held on 8-10 June 2021.

The three strategic priorities set by the document are:

1. To maximize equitable and equal access to comprehensive people-centered HIV services.

2. To break down legal and societal barriers to achieving HIV outcomes.

3. To fully resource and sustain HIV responses and integrate them into systems for health, societal protection and humanitarian settings.

Advocates have been analyzing the strategy to identify how it can be used to advance advocacy priorities. This brief outlines some of the targets set by the strategy that may be helpful for people who use drugs and the organizations representing their interests.

What we can use to move our agenda forward

The strategy set a series of testing and treatment targets to be achieved for all subpopulations and age groups, including 95% of women of reproductive age to have their HIV and sexual and reproductive health service needs met; 95% of pregnant and breastfeeding women living with HIV to have suppressed viral loads; and 95% of HIV-exposed children to be tested by 2025. Although these targets are not population specific, advocates and activists can use them to ensure implementation of policies to end AIDS are equitable and include women who use drugs, who often face discrimination by policymakers and health providers.

Essential for our community is a series of '10-10-10 targets' which seek:

1. Less than 10% of countries have punitive legal and policy environments that deny or limit access to services,
2. Less than 10% of people living with HIV and key populations experience stigma and discrimination,
3. Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.

These targets will require us to be vigilant and document possible violations or progress toward each objective. Country legislation can be analysed to emphasise examples of policies which go against the first objective. It will be necessary to put in place mechanisms to document stigma, discrimination, gender inequality, and violence from the point of view of key populations.

These targets translate into several sub-objectives that are highly relevant to people who use drugs, including

1. Less than 10% of countries criminalising sex work, possession of small amounts of drugs, same-sex behavior and HIV transmission, exposure or non-disclosure by 2025,
2. Less than 10% of key populations experiencing physical or sexual violence by 2025,
3. Less than 10% of key populations (i.e., gay and bisexual men, sex workers, transgender people, people who inject drugs and prisoners) reporting stigma and discrimination by 2025, and
4. Less than 10% of law enforcement officers report negative attitudes towards key populations by 2025.

These targets will also require vigilance by pushing for a clear definition of what constitutes a small amount of drugs, a community-led monitoring mechanism to document physical and sexual violence, stigma, discrimination, as well as a way to assess attitudes by law enforcement to achieve the 10% target.

The strategy includes some specific provisions that are extremely important as they aim at 90% of people who inject drugs having access to comprehensive harm reduction services integrated or linked to hepatitis C, HIV, and mental health services, as well as at 80% of service delivery for HIV prevention programs for key populations and women to be delivered by community-, key population-and women-led organizations. Although this target does not have a clear deadline (e.g., 2025), it goes beyond the old target set by the 2016 Political Declaration and can be used as a powerful tool to influence funding decisions, including country

dialogues starting right now, as well as influence the rest of Global Fund-funded projects and programs.

Achieving the goals and targets of the new Strategy requires that annual HIV investments in low- and middle-income countries rise to a peak of US$ 29 billion (in constant 2019 dollars) by 2025. The strategy also set new targets to improve the social enabling environment, which will need to reach US$ 3.1 billion per year by 2025.

Conclusions

All official documents from UN agencies can provide quotable material and targets to move our advocacy agenda forward. However, most of these documents are just paper exercises as they are not attached to specific financial commitments from member states (though there are 2025 funding targets). Unless we decide to use them to hold the signatories accountable (for the UNAIDS strategy, that means all 193 countries that are members of the United Nations since the document was unanimously approved), this strategy will not produce much change and progress.

We should also be aware that we are very far from where we need to be. For example, despite the commitment to ensure that at least 30% of all service delivery is community-led by 2030, only 3.3% of HIV funds went to programs for people who inject drugs between 2010 and 2014. Harm Reduction International's Global State of Harm Reduction reported that harm reduction funding in low- and middle-income countries amounted to USD $188 million, just 13% of the $1.5 billion per year UNAIDS estimates as necessary for an adequate harm reduction response.

Setting a 90% target of people who use drugs having access to harm reduction services comes at no cost for UNAIDS and will likely fade away unless we act upon it. Engaging in budget monitoring activities while pushing financing organizations like the Global Fund and PEPFAR to honor these commitments should become one of our key advocacy priorities. At the same time, we shouldn't expect countries to establish a credible monitoring mechanism to measure progress toward the "10-10-10" targets, which means that community-led monitoring of the criminalization of drug use and possession as well as stigma, violence, discrimination, and negative attitude by law enforcement should also become one of the key priorities for us as a community.

The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs, and their impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national and regional levels.

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