Our Rights, Every Body's Rights

Technical Assistance Module for Drug User-led Advocacy

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

For the first time, the world has committed to decriminalise drug use and possession, end stigma and discrimination and gender inequality and fund community-led responses on action towards these targets. People who use drugs must be in the driver's seat on advocacy and service delivery. This manual will be a critical tool in our toolbox we can use to hold governments accountable to fully respect our rights and dignity.

Judy Chang, Executive Director, INPUD

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CHAPTER PAGE

01 INTRODUCTION

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 exposes and challenges stigma, discrimination, and the criminalisation of people who use drugs, and their impact on the drug-using community's health and rights. INPUD is a movement of people who use drugs (currently and formerly) who support the Vancouver Declaration. The Vancouver Declaration sets out the demands of people who use drugs, emphasising that their human rights must be respected, and their health and well-being prioritised. INPUD is a global network that seeks to represent people who use drugs in international agencies such as the United Nations and with those undertaking international development work. It believes that people who use drugs should be meaningfully represented in the decision-making processes that affect their lives. INPUD is committed to supporting people who use drugs to engage in advocacy for decriminalisation of drug use and other drug policy and law reform.

02 PURPOSE OF THE TOOLKIT

Legal, regulatory and policy frameworks can play a significant role in protecting and promoting the right to health for people who use drugs by ensuring access to HIV and related services. Conversely, laws that criminalise drug use and aggressive law enforcement, which is both underpinned by and exacerbate stigma, discrimination and violence against people who use drugs can exacerbate the vulnerability of people who use drugs, create barriers to their access to essential HIV services, harm reduction and protection against overdose and increase the impact of HIV, poor sexual and reproductive health on their lives.

It is recognised that *"criminalisation of drug use, restrictive drug policies and aggressive law-enforcement practices are key drivers of HIV and hepatitis C epidemics among people who inject drugs",*[1] a view that is shared by several United Nations agencies[2,3]. The Global Commission on HIV and the Law has recognised that these factors, together with fear of arrest, discrimination, marginalisation, stigmatisation and violence, drive people who inject drugs underground and exclude them from proper access to the harm reduction and health services they need to prevent overdose and protect themselves from HIV and hepatitis C.[4]

The purpose of this manual is to be a resource for conducting trainings for strengthening the capacity of people who use drugs to effectively advocate for progress on the 10-10-10 social enabler targets recently adopted in the Global AIDS Strategy and 2021 Political Declaration on HIV/AIDS, (particularly in regard to decriminalisation and the removal of punitive policies) as well as on the 30-60-80 targets on community led responses to HIV ; and to hold governments accountable for implementing law and policy change in order to reach these targets.

1. Science addressing drugs and HIV: state of the art of harm reduction. A scientific statement. Vienna: United Nations Office on Drugs and Crime; 2014. Science addressing drugs and HIV: state of the art. 2nd scientific statement. Vienna: United Nations Office on Drugs and Crime; 2016.
2. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. Geneva: World Health Organization; 2016.
3. Do no harm: health, human rights and people who use drugs. Geneva: Joint United Nations Programme on HIV/AIDS; 2016.
4. 188GCHL. *Report of the Africa Regional Dialogue on HIV and the Law*, 2011 - https://hivlawcommission.org/regional-dialogue-resources/africa-downloads/

03 HOW TO USE THIS MANUAL

This manual contains both content and interactive learning activities for use by facilitators to run a capacity strengthening workshop for people who use drugs on advocacy for drug policy. By the end of the workshop participants will have been supported to develop an advocacy roadmap or action plan to take their drug policy advocacy forward. The manual is accompanied by a set of powerpoint slides (Annexure A) and handouts (Annexure B) for use by the facilitator.

Each Unit begins with a note for facilitators in a shaded box that sets out:

- The aim of the session
- The suggested duration of the session
- The learning objectives and expected outcomes of the session
- Instructions on how to facilitate the session, including information on the slides to be presented at the session and on the learning activity for the session (where applicable)
- The materials that will be required to facilitate the session (flip charts, marker pens etc).

The manual consists of six units. The first two units provide an introduction to the workshop. Unit 3 provides an introduction to the impact of criminalisation of drug use on people who use drugs. Unit 4 looks at why drug use is a human rights issue and Unit 5 provides information on the new targets contained in the 2021 Political Declaration on HIV and AIDS by 2030: Ending Inequalities and Getting on Track to End AIDS by 2030, and in the UNAIDS Global AIDS Strategy 2021-2026: End Inequalities. End AIDS and how to use these in their advocacy. Finally, Unit 6 provides a practical guide to advocacy and takes participants through a step-by-step approach to developing an advocacy action plan or roadmap.

It is strongly recommended that at least one of the trainers/facilitators comes from the community of people who use drugs. This is to ensure that people who use drugs have the capability and capacity to take on the leadership role throughout the process. This manual is designed for network of people who use drugs at national and regional level; therefore, it is important to have a facilitator who is familiar with the national/regional context and to ensure participation of representatives of the national/regional network in order to identify specific contexts that may be included and adapted.

The following section provides a model workshop agenda to guide facilitators in the design of the drug policy advocacy capacity strengthening workshop.

04 MODEL WORKSHOP PROGRAMME

DAY ONE

09.00-09.30	**REGISTRATION**	
09.30-09.45	**Unit 1:** Welcome, Opening and Logistic • Logistic and housekeeping • Security • Harm reduction services	Opening remarks from INPUD Welcome remarks from local organiser
09.45-10.30	**Unit 2:** Introduction and Expectations • Synopsis of the workshop • Workshop rules • Getting to know each other • Participants' expectations • Workshop agenda	Lead Facilitator & co-Facilitator
10.30-10.45	**TEA BREAK**	
10.45-11.30	**Unit 3:** Impact of Criminalisation of Drug Use and Possession • Aim • Impact on human rights violation • Policy in practice • Impact of criminalisation • Global AIDS Targets and Political Commitment as an opportunity and important momentum Group work: impact of criminalisation to individual's life	Lead Facilitator & co-Facilitator
11.30-12.30	Continue Unit 3	Lead Facilitator & co-Facilitator

12.30-13.30	**LUNCH BREAK**	
13.30-15.00	**Unit 4:** Drug use is Human Rights • Internationally agreed guidelines, treaties, conventions, commitments • Gaps in international instruments on human rights • International Guidelines on Human Rights and Drug Policy • INPUD's consensus statement • Understanding models of decriminalisation Activity: assessing the human rights aspects in the context of national and/or regional drug law and policy	Lead Facilitator & co-Facilitator
15.00-15.15	**TEA BREAK**	
15.15-17.00	Continue Unit 4: • Group presentation	Lead Facilitator & co-Facilitator

DAY TWO

09.00-09.30	Recap of Day 1	Local organisers
09.30-10.30	**Unit 5:** New Targets, How to Use Them? • Overview of the 2025 targets and how far behind are we in achieving the 2025 and 2030 targets • Community-led responses • Decriminalisation targets • Using these targets in our advocacy – the 2021 Political Declaration on HIV and AIDS. Digging deeper into the human rights, community leadership, stigma and discrimination, prevention, test and treatment, women who use drugs, and accountability. Group work: identifying ways and opportunities that these targets may bring, based on region and country-specific context	Lead Facilitator & co-Facilitator
10.30-10.45	**TEA BREAK**	
10.45-12.30	Continue Unit 5:	Lead Facilitator & co-Facilitator
12.30-13.30	**LUNCH BREAK**	
13.30-15.00	Continue Unit 5: • Group Work	Lead Facilitator & co-Facilitator
15.00-15.15	**TEA BREAK**	
15.15-17.00	Continue Unit 5: • Group Presentation	Lead Facilitator & co-Facilitator

DAY THREE

09.00-09.30	Recap of Day 2	Local Organisers
09.30-10.30	Unit 6: Practical Guidance for Advocacy • What is advocacy? • Principals in advocacy • Planning your advocacy agenda (steps in developing advocacy plan)	Lead Facilitator & co-Facilitator
10.30-10.45	**TEA BREAK**	
10.45-12.30	Group Work: Developing Advocacy Plan • Identifying priority issues using a problem tree approach • Group presentation and feedback • Research and analysis • Identifying existing and gaps in evidence	Lead Facilitator & co-Facilitator
12.30-13.30	**LUNCH BREAK**	
13.30-15.00	Group Work: Developing Advocacy Plan • Developing our advocacy goal and targets • Group presentation and feedback	Lead Facilitator & co-Facilitator
15.00-15.15	**TEA BREAK**	
15.15-17.00	Group Work: Developing Advocacy Plan • Identifying decision making spaces, and how do make ourselves accountable for our representation • Identifying stakeholders, allies and non-allies • Identifying different advocacy methods • Identifying resources to support our advocacy Group presentation and feedback	Lead Facilitator & co-Facilitator

DAY FOUR

09.00-10.30	Group Work: Developing Advocacy Plan • Finalising advocacy roadmap	Lead Facilitator & co-Facilitator
10.30-10.45	**TEA BREAK**	
10.45-12.30	Group Work: Developing Advocacy Plan • Developing a monitoring, evaluation and learning framework	Lead Facilitator & co-Facilitator
12.30-13.30	**LUNCH BREAK**	
13.30-15.00	Group Presentation on Advocacy Roadmap & Feedback	Lead Facilitator & co-Facilitator
15.00-15.15	**TEA BREAK**	
15.15-17.00	Group Presentation on Advocacy Roadmap & Feedback	Lead Facilitator & co-Facilitator

DAY FIVE

09.00-10.00	Plenary Presentation: Consolidated Advocacy Roadmap & Feedback	Lead Facilitator & co-Facilitator
10.00-10.15	**TEA BREAK**	
10.15-11.30	Moving Forward: What's next and how do we use our advocacy roadmap	Lead Facilitator & co-Facilitator
11.30-12.00	Closing	Closing remarks from local organisers and INPUD

FACILITATORS NOTE

This training manual has been piloted during three initial training workshops with people who use drugs in three different countries (South Africa, Nigeria and Indonesia). Based on lessons learned from these pilot workshops, facilitators are encouraged to:

- Know your audience and tailor the level of presentations and facilitation to the level of prior knowledge of drug laws and policy and engaging in advocacy for drug policy and law reform. You may, for example, have to spend more time on exploring and explaining what decriminalisation of drug use and possession for own use means. It may also be useful to make provision in your workshop programme for a presentation and discussion by sex workers on what decriminalisation means for them and to share examples of how they have gone about moving the decriminalisation agenda forward. You can address a mixed level of prior knowledge and skills by ensuring that all participants have the opportunity to speak, and that the groups in which participants are divided for group work are balanced in terms of the range of skills and expertise.
- If your workshop participants are not fluent in English, take the time to have the slides and handouts and as many of the background materials as possible translated into the language in which the participants are fluent.

05 WORKSHOP UNITS

Unit 1 Opening, Welcome and Administration

FACILITATORS NOTE

Duration: 15 minutes

Slides to be presented: Slides 2

Aim: To set the scene for the workshop and manage expectations

Steps:

- Welcome participants to the workshop.
- Thank participants for their time, reminding them that people who use drugs have an important role in advocating and implementing evidence and human rights-based policy and practice.
- Introduce yourself and provide some background that is relevant to the training.
- Tell participants where the bathrooms are, where catering will be provided and where sterile injecting equipment and Naloxone can be found, including any security matters that participants may need to be aware of.
- Request that people complete an attendance form, including contact details for later networking between partners.
- Any other housekeeping information.

Materials Needed:

- Attendance register
- Name tags (optional)

Unit 2 Introductions, Expectations and Objectives

FACILITATORS NOTE

Duration: 45 minutes

Slides to be presented: Slides 3-6

Aim: To understand participants' knowledge and experience and workshop expectations

Learning objectives:

- To facilitate networking between participants
- To understand participants' expectations
- To inform participants about the workshop structure and objectives

Main points: Clarification of expectations, objectives and workshop structure

Expected outcomes:

- Establishment of new relationships between people who use drugs who are active in their communities
- Clarification of expectations and stated objectives and process to achieve these

Materials Needed

- Projector
- Flipchart and marker pens

Unit components:

1. Synopsis (presentation)
2. Ground rules
3. Introductions and expectations (activity)
4. Overview of the agenda

1. SYNOPSIS

Duration: 2 minutes

Slides to be presented: Slide 3

Open the training by saying:

In all parts of the world, people who use drugs are disproportionately affected by HIV and the hepatitis C virus (HCV).

The main factors contributing to this situation are limited access to evidence-based interventions, particularly needle and syringe programmes, opioid agonist therapy and treatment for HIV and HCV infection in contexts where people who use drugs are criminalised and stigmatised.

This workshop is designed to assist people who use drugs to effectively advocate for progress on the 10-10-10 societal enabler targets recently adopted in the Global AIDS Strategy and 2021 Political Declaration on HIV/AIDS, (particularly in regard to decriminalisation and the removal of punitive policies) as well as on the 30-60-80 targets on community led responses to HIV; and to hold governments accountable for implementing law and policy change in order to reach these targets.

For the first time in the history of the global HIV response, societal enablers and the community-led responses are included in the Global AIDS Targets and Political Declaration Commitments. More importantly, these targets and commitments include specific reference to decriminalisation of drug use and possession among other as important targets and commitments. As good as it may sound, our government will continue to do business as usual, especially without any pressure from the community. In 2025, countries will come together again to set new targets, and we may not have this opportunity anymore.

2. GROUND RULES:

Duration: 2 minutes

Slides to be presented: Slide 4

Clarify the ground rules that will guide the workshop. Elicit these from the participants.

3. INTRODUCTION OF ICEBREAKER EXERCISE:

Duration: 1 minute

Inform participants that they will take part in an exercise to get to know one another and understand their expectations of the workshop.

Activity: Icebreaker and expectations

Duration: 20 minutes

Slides to be presented: Slide 4

Aim: To allow participants to get to know one another and understand their expectations of the workshop

Steps:

- Ask participants to identify another person in the training that they have not met, or do not know very well.
- Ask each pair to introduce themselves to each other, including some background on why they got involved with or want to get involved with advocacy for drug policy and law reform.
- Each person must also share their main expectations of the workshop.
- After five minutes bring people back together and ask them to introduce their partner (name and background) and their expectations.
- Note the expectations on a flipchart.
- After everyone has presented, review the expectations and discuss them in relation to the workshop's main objective (listed below).
- Take note of expectations and tailor the workshop to cover these as far as possible.

4. OVERVIEW OF THE AGENDA

Duration: 2 minutes

Slides to be presented: Slide 6

Briefly go through the workshop agenda with participants. Explain to participants that there are a lot of information and materials to be covered, and that most important part of the workshop is the roadmap development. Encourage participants to fully participate and contribute to each session and to maximise the allotted time.

Unit 3: An introduction to the impact of criminalisation of drug use on people who use drugs

FACILITATORS NOTE:

Duration: 4 hours 15 minutes

Slides to be presented: Slides 7-20

Aim of session: To provide participants with data and information about the impact of criminalisation on people who use drugs that they can use in their advocacy

Learning objectives:

1. To inform participants of the extent of criminalisation of possession, use and cultivation of small amounts of drugs globally and the impact of criminalisation on the health and human rights of people who use drugs.
2. To provide participants with data on the impact of criminalisation for use in their advocacy.
3. To provide participants with a better understanding of why it is important to be familiar with the data on the various impacts of criminalisation for the purposes of their advocacy.

Expected outcomes:

1. Participants have a better understanding of the extent of criminalisation of possession, use and cultivation of small amounts of drugs globally and the impact of criminalisation on the health and human rights of people who use drugs.
2. Participants have access to data on the impact of criminalisation for use in their advocacy.
3. Participants have a better understanding of why it is important to be familiar with the data on the various impacts of criminalisation for the purposes of their advocacy.

Steps:

- Explain the aim of this session
- Explain that it is important to be familiar with the data on the various impacts of criminalisation as this data can help participants to better understand the impact of criminalisation, to plan their key advocacy messages and to strengthen their arguments with policy makers.
- Activity: Break the participants up into three groups and ask them to brainstorm and agree on the three main impacts that criminalisation has on their lives. Ask the groups to note the three main impacts on a flipchart. Reconvene the participants, ask each group to share their three main impacts and facilitate a short discussion to explore the similarities (or differences) between the three main impacts selected by each group.

Presentation: Present the information to be covered in this session contained in slides 10-20

Materials Needed

- Projector
- Flipchart and marker pens

INFORMATION TO BE COVERED IN THIS SESSION:

"People do not lose their human rights because they use drugs. I put to you that they have the same rights as all of us: to health and to life, to non-discrimination, to freedom from arbitrary arrest and detention, and to freedom from torture and other forms of ill treatment. The State's response to an individual's drug use should always be compassionate, focus on that individual's health and well-being, with full respect for dignity and rights".[5] Zeid Ra'ad Al Hussein, former United Nations High Commissioner for Human Rights

People who use drugs face daily human rights violations in the form of stigma and discrimination, physical and psychological harassment, abuse, and violence by police, coerced drug "rehabilitation" in settings whose programs lack therapeutic rationale or benefit, compulsory HIV testing, and the denial of health care services, employment, and social benefits. These rights violations are largely underpinned by laws that criminalise the possession, use and cultivation of small amounts of illicit drugs.

We know that criminalisation drives people who use drugs underground leading to unsafe practices which, in turn, increase the risk of infection for both themselves and their sexual partners in the wider community[6]. Criminalisation of drug users undermines HIV prevention and treatment[7] and thus the likelihood of achieving Sustainable Development Goal (SDG) 3 of ensuring healthy lives and promoting well-being for all at all ages. In particular, the criminalisation of drug users undermines the realisation of SDG 3.3 of ending the AIDS epidemic by 2030. Studies have shown that punitive and discriminatory laws are associated with high HIV incidence and prevalence, where stigma and laws criminalising drug use and possession increase HIV risks. The criminalisation of drug use and possession entrenches discrimination and marginalises populations already facing exclusion and oppression, severely impeding access to health and social protection. Conversely, peer-reviewed studies have shown that

5. Statement by Mr. Zeid Ra'ad Al Hussein, United Nations High Commissioner for Human Rights at the United Nations Work on the World Drug Problem, 2015: https://www.ohchr.org/en/statements/2015/11/statement-mr-zeid-raad-al-hussein-united-nations-high-commissioner-human-rights?LangID=E&NewsID=16791
6. GCHL, Risks, Rights and Health: Supplement (July 2018). https://hivlawcommission.org/wp-ontent/uploads/2018/09/Hiv-and-the-Law-Supplement-Exec-Summary-2018_Final.pdf
7. DeBeck, K., et al., (2017), HIV and the Criminalisation of Drug Use Among People Who Inject Drugs: A Systematic Review, Lancet HIV 2017; 4:e357-74. Available at: https://www.thelancet.com/pdfs/journals/lanhiv/PIIS2352-3018(17)30073-5.pdf?code=lancet-site; Mayer, L., et al., (2017), Collateral Damage and the Criminalization of Drug Use, The Lancet HIV, volume 4, No. 8, e326-e327, August 2017.Available at: https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(17)30071-1/abstract.

decriminalisation is fundamental to an effective HIV response, demonstrating significant results in reducing HIV incidence and improving overall health outcomes. Modelling estimates have indicated that the decriminalisation of drug use is linked to 14% increased knowledge of HIV status and viral suppression[8].

In 2016 UN Member States agreed at the 2016 United Nations General Assembly Special Session (UNGASS) to an outcome document that took an important step forward: it called for effective public health measures to improve health outcomes for people who use drugs, including programmes that reduce the impact of the harms associated with drug use. The outcome document also urged countries to fully respect the human rights and fundamental freedoms of people who use drugs, and to consider alternatives to punishment for drug offences. While some progress has been made, an assessment of the implementation of the operational recommendations included in the 2016 United Nations General Assembly Special Session (UNGASS) on Drugs Outcomes Document illustrates that the gap between policy commitments on paper and meaningful change on the ground has continued to widen[9].

World Health Organisation (WHO) data shows an increase in the number of people who died of 'drug use disorders' from 154,811 in 2015 to 181,758 in 2019, with the total number of deaths associated with drug use (including those related to HIV and hepatitis C) estimated at 585,000 in 2017, 30% of which are caused by overdose.

People who inject drugs are at increased risk of HIV, tuberculosis (TB), and viral hepatitis B and C (HBV and HCV), in addition to overdose. Globally, around 11 million people inject drugs. Approximately 1 in 8 (or 1.4 million) of these people are living with HIV (UNODC World Drug Report, 2020), while 39.4% have viremic HCV infection. The risk of acquiring HIV is 35 times higher among people who inject drugs[10].

Injecting drug use accounts for approximately 10% of new HIV infections globally (UNAIDS, 2020). And an estimated 23–39% of new HCV infections occur among people who inject drugs. Globally, 1 in 3 HCV deaths are attributable to injecting drug use. In some regions, such as Eastern Europe and Central Asia, prevalence rates for both HIV and HCV are particularly high. Furthermore, there are approximately 2.3 million HIV–HCV co-infections worldwide, of which more than half (1.3 million) occur in people who inject drugs (WHO, 2016).

New HIV infections among people of all ages worldwide declined by 23% between 2010–2019, but there is no evidence of a change in global incidence among people who inject drugs—and in some regions incidence has increased[11,12].

8. Kavanagh, Matthew M et al. "Law, criminalisation and HIV in the world: have countries that criminalise achieved more or less successful pandemic response?." BMJ global health vol. 6,8 (2021): e006315. doi:10.1136/bmjgh-2021-006315
9. IDPC, Taking Stock Of Half A Decade Of Drug Policy An Evaluation Of UNGASS Implementation, 2021
10. https://www.unaids.org/en/resources/fact-sheet
11. UNAIDS. Seizing the moment: tackling entrenched inequalities to end epidemics–global AIDS update. Geneva: UNAIDS; 2020
12. UNAIDS. Key Population Atlas (https://kpatlas.unaids.org/ dashboard, accessed 7 April 2022)

Among the immediate causes of these disparities is the lack of consistent access to sterile injecting equipment, opioid agonist therapy (OAT), community-distribution of naloxone, condoms and lubricant, HIV testing and antiretroviral therapy (ART) for those who are living with HIV, and affordable diagnostic and treatment of Hepatitis C.

The 2021 Global State of Harm Reduction Report[13] reported that:

- The total number of countries implementing needle and syringe programmes (NSP) had increased by just one, from 86 in 2020 to **87**.
- Two new countries (Uganda and Mozambique) had begun implementing opioid agonist therapy (OAT) programmes since 2020. The total number of countries implementing OAT in 2021 was **86** (up from 84 in 2020)
- The total number of countries with explicit supportive references to harm reduction in national policy documents in 2021 is **98**.
- There is a **95%** funding gap for harm reduction in low-and middle-income countries.

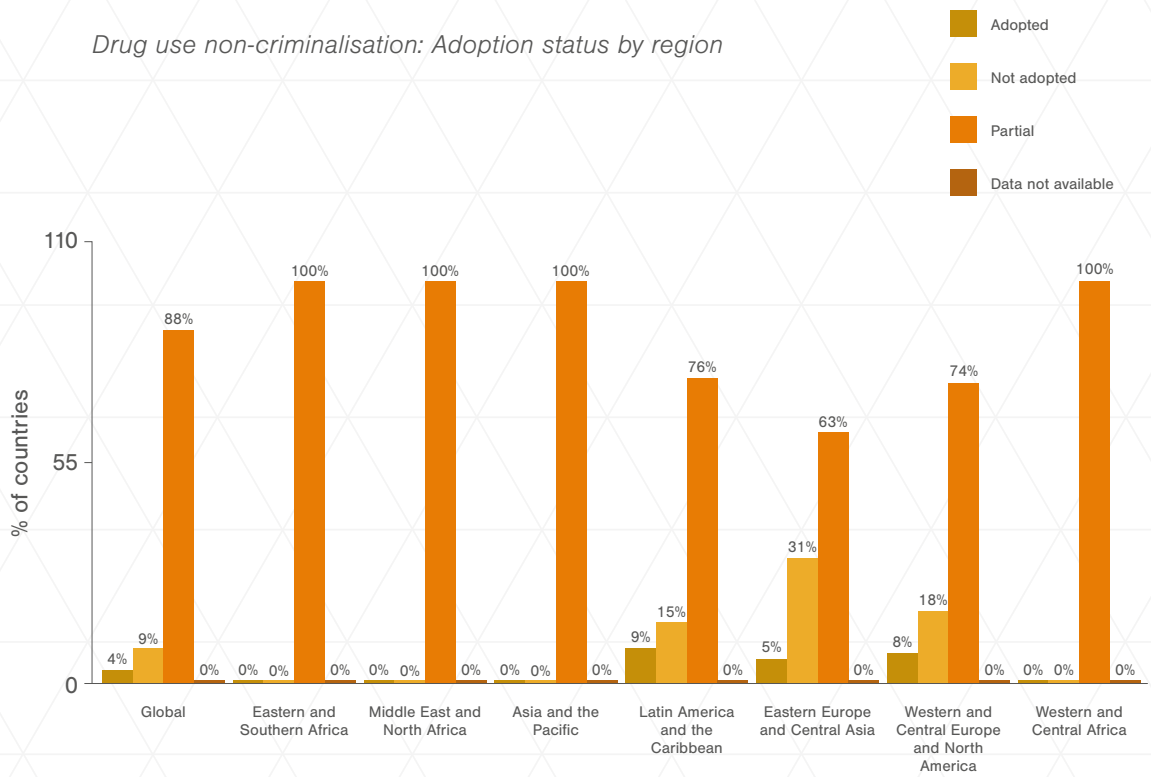
Women continue to be disproportionately impacted by punitive drug control measures. Women who use drugs are particularly vulnerable to health harms, but their access to gender-sensitive harm reduction and treatment services has not improved. Stigma, criminalisation, fear of loss of child custody and other punitive measures play a major role in deterring women from accessing the services that do exist. The proportion of women incarcerated for drug offences remains high at 35% of women deprived of their liberty globally[14].

Although the international drug conventions do not automatically require the imposition of conviction and punishment for drug-related offences, including those involving the possession, purchase or cultivation of illicit drugs, in appropriate cases of a minor nature or when committed by drug users, work undertaken by drug user advocates to hold governments accountable for protecting and upholding the human rights of people who use drugs and to advance the decriminalisation agenda by drug user advocates has been both challenging and frustrating.

As illustrated in the graph overleaf, globally 189 countries still fully criminalise drug use or possession.[15] Even among the 8 countries that have adopted and 17 countries that have partially adopted the so-called decriminalisation, administrative sanctions are still imposed towards people who use drugs, and that the community remains as subject of violence, abuse, ill-treatment, social exclusion, stigmatisation, and discrimination.

13. The global state of harm reduction 2021. London: Harm Reduction International; 2021.
14. IDPC op cit
15. HIV Policy Lab: Global HIV Policy Report, March 2022 at https://hivpolicylab.org/documents/reports/2021GlobalReport/Global%20HIV%20Policy%20Report%20-%20Findings%20from%20the%20HIV%20Policy%20Lab%20%5BHighRes%5D.pdf

Drug use non-criminalisation: Adoption status by region



The adoption in March 2021 of the new Global AIDS Strategy 2021-2026: End Inequalities. End AIDS and in June 2021 of the Political Declaration on HIV and AIDS : Ending Inequalities and Getting on Track to End AIDS by 2030, presents us with a window of opportunity in the form of a set of new and ambitious targets on which to focus our advocacy efforts to remove laws that criminalise drug possession and use that present a major barrier to access to HIV services for people who use drugs and to increase community-led responses to HIV for people who use drugs. The Political Declaration is the first of all of the Political Declarations on HIV and AIDS that contains an explicit reference to people who use drugs as well as a target of less than 10% of countries criminalising drug use and possession of small amounts of drugs by 2025 and thus presents us with a rare opportunity to advance the decriminalisation agenda. This is an opportunity not to be missed and people who use drugs should take optimum advantage of it to advocate for decriminalisation.

Unit 4: Drug Use is a Human Rights Issue

FACILITATORS NOTE

Duration: 2 hours 30 minutes

Slides to be presented: Slides 21-29

Aim: To provide participants with data and information about the relationship between criminalisation of drug use and human rights that they can use in their advocacy and to familiarise participants with the international guidelines on human rights and drug policy

Learning objectives:

- Participants will learn about the relationship between criminalisation of drug use and human rights that they can use in their advocacy
- Participants will learn about the international guidelines on human rights and drug policy

Expected outcomes:

- Participants will have a better understanding of relationship between criminalisation of drug use and human rights that they can use in their advocacy
- Participants will be familiar with the international guidelines on human rights and drug policy

Steps:

- Explain the aim of this session
- Present the information to be covered in this session contained in slides 21-29
- Ensure that you leave sufficient time for questions by participants.

Key Points:

Ensure participants understand the different international conventions on drug policy are driven by prohibition. Therefore, it may be difficult to challenge. HIV has been the space where communities have been able to push for the fulfillment of human rights of people who use drugs, including needles and syringes, opioid agonist therapy, naloxone, etc. The next chapter will explain the opportunity to advance decriminalisation agenda through the HIV lens.

Materials Needed

- Projector
- Flipchart and marker pens

Information to be covered in this session:

"Reliance on criminal sanctions as the major response to illicit drug use inevitably results in the denial of human rights of the injecting drug user (IDU) population as drug use remains defined as a law enforcement rather than a health problem. Poor health outcomes in this population then follow, because health promotion and health care services are more difficult to provide to a now stigmatised and underground population.

Protection of human rights is an essential precondition to improving the health of individual drug users and improving the public health of the communities where they live[16]."

Since the late 1990s, United Nations (UN) General Assembly resolutions have acknowledged that 'countering the world drug problem' must be carried out 'in full conformity' with 'all human rights and fundamental freedoms[17]'. This has been reaffirmed in every major UN political declaration on drug control since, and in multiple resolutions adopted by the Commission on Narcotic Drugs[18].

The UN System Common Position on drug policy[19], adopted in November 2018 by the UN System Chief Executives Board for Coordination (CEB), commits to 'supporting Member States in developing and implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented, and sustainable responses to the world drug problem, within the framework of the 2030 Agenda for Sustainable Development'. The Common Position is based on a strong mandate given by the General Assembly to the CEB and the Secretary-General to improve UN system-wide coherence, and incorporates many elements from the 2016 UNGASS, the SDG framework and human rights instruments that have all been adopted by Member States.

In the Common Position document, UN agencies commit to promoting alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use and to call for changes in laws, policies and practices that threaten the health and human rights of people.

While the Common Position is non-binding on Member States, it has been developed on the basis of a strong mandate the General Assembly has given to the CEB and the UN Secretary-General to improve UN system-wide coherence. It incorporates many elements from the 2016

16. Wodak, Alex. 1998. "Health, HIV Infection, Human Rights, and Injecting Drug Use." Health and Human Rights, Vol. 2, No. 4, 24–41. 1998
17. See, e.g., UN General Assembly, Resolution 73/192: International Cooperation to Address and Counter the World Drug Problem, UN Doc. A/RES/73/192 (2019).
18. UN General Assembly, Resolution S-20/2: Political Declaration, UN Doc. A/RES/S-20/2 (1998), annex, preamble; Political Declaration and Plan of Action on International
Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, High-Level Segment of the Commission on Narcotic Drugs, Vienna,
11–12 March 2009, UN Doc. E/2009/28-E/CN.7/2009/12 (2009), para. 1; UN General Assembly, Resolution S-30/1: Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem, UN Doc. A/RES/S-30/1 (2016), annex, preamble.
19. https://vngoc.org/wp-content/uploads/2019/07/CEB-2018-2-SoD_Common-position.pdf

UNGASS, the SDG framework and human rights instruments that have all been adopted by Member States, and therefore cannot be easily dismissed by Member States.

However, despite the inclusion of key principles on human rights, the implementation of UNGASS Outcome Document have been driven by prohibition, criminalisation and continuous violation of human rights. In addition progress towards the realisation of these commitments and the human rights implication on drug policies lacks monitoring mechanisms[20].

The *International Guidelines on Human Rights and Drug Policy*[21], which are elaborated on in the table below, highlight the measures that governments must take to comply with their human rights obligations.

The Guidelines set out what human rights law requires of States in the context of drug control law, policy, and practice and highlight the measures States should undertake or refrain from undertaking in order to comply with their human rights obligations, while taking into account their concurrent obligations under the international drug control conventions: the 1961 Single Convention on Narcotic Drugs (as amended); the 1971 Convention on Psychotropic Substances; and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. They do not invent new rights but apply existing human rights law to the legal and policy context of drug control in order to maximise human rights protections, including in the interpretation and implementation of the drug control conventions.

The UN System Common Position on drug policy as well as the International Guidelines on Human Rights and Drug Policy and the international human rights instruments on which the Guidelines are based are all really important tools for advocacy to push the decriminalisation agenda with governments as they contain commitments that governments can and must be held accountable for.

It is important to remember that all human rights are indivisible, interdependent, and interrelated. This means that the violation of one right will negatively impact on the enjoyment of other rights. For example, if your right to be equal and free from discrimination is violated by health care providers who discriminate you because you use drugs, you will be reluctant to return to the health are facility – thus your right to health is negatively affected. Similarly, if the law does not permit the registration of community-led organisations of and for people who use drugs, not only is this a violation of your right to freedom of association but also to your right to participate in public life – in this context your right to meaningful participation in the design, implementation and assessment of drug laws and policies that directly impact on your health and life.

Everyone has the right to participate in public life. This includes the right to meaningful participation in the design, implementation, and assessment of drug laws, policies, and practices,

20. https://inpud.net/wp-content/uploads/2022/01/INPUD-submission-to-the-Office-of-the-High-Commissioner-on-Human-Rights-Final.pdf
21. The content of this section is based on excerpts from The International Guidelines On Human Rights And Drug Policy, 2019, UNDP, UNAIDS, WHO and ICHRDP https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy

particularly by those directly affected. In order to ensure meaningful participation of people who use drugs it is critical that legal barriers that unreasonably restrict or prevent the participation of affected individuals and communities in the design, implementation, and assessment of drug laws, policies, and practices are removed.

The table below outlines some of the common human rights violations faced by people who use drugs as a result of criminalisation and the actions that should be taken by governments to fulfil their obligation to protect and uphold these rights:

Human right	Common drug-related rights violations faced by people who use drugs	Action to be taken by governments
Freedom from arbitrary arrest and detention	In some countries people who are charged under drug laws are not entitled to be released on bail and custodial sentences for convictions under drug laws are mandatory. In others, people who use drugs are sentenced to mandatory drug ''treatment'' programmes where they face cruel and degrading treatment.	Ensure that people are not detained solely on the basis of drug use or drug dependence. Ensure that pre-trial detention is never mandatory for drug-related charges and is imposed only in exceptional circumstances where such detention is deemed reasonable, necessary, and proportional. Guarantee that people arrested, detained, or convicted for drug-related offences can benefit from the application of the same noncustodial measures – such as bail or other alternatives to pre-trial detention; sentence reduction or suspension; parole; and pardon or amnesty – enjoyed by those who are arrested, detained, or convicted of other crimes. Prioritise diversion from prosecution for persons arrested for drug offences or drug-related offences of a minor nature. Prioritise non-custodial measures at the sentencing and post-sentencing stages for persons charged with or convicted of drug offences or drug-related offences of a minor nature. Ensure that, where treatment is court mandated, no penalties attach to a failure to complete such treatment. Ensure that treatment for drug dependence as an alternative to incarceration is undertaken only with informed consent and where medically indicated, and under no circumstances extends beyond the period of the applicable criminal sentence. Take immediate measures to close compulsory drug detention centres where they exist, release people detained in such centres, and replace such facilities with voluntary, evidence-based care and support in the community.

Human right	Common drug-related rights violations faced by people who use drugs	Action to be taken by governments
Health	Stigma and discrimination by health care providers, fuelled by laws that criminalise drug possession and use. Lack of access to harm reduction services and drug dependence treatment.	Ensure that drug-related and other health care goods, services, and facilities are available on a non-discriminatory basis, accessible, affordable and of good quality. Address stigma and discrimination against people who use drugs, including the social and health determinants of health. Remove legal and policy barriers to access to controlled substances for medical purposes and to health goods, services, and facilities for the prevention of harm, ensure access to harm reduction among those who use drugs, safe supply and drug dependence treatment. Consider using the available flexibilities in the UN drug control conventions to decriminalise the possession, purchase, or cultivation of drugs for personal consumption.
Protection from torture and other forms of cruel, inhuman or degrading treatment	People in ''drug treatment and rehabilitation centres'' are often subjected to cruel, inhuman and degrading treatment. What is referred to as "treatment" in many treatment centers in fact includes painful, unmedicated withdrawal, beatings, military drills, verbal abuse, and sometimes scientific experimentation without informed consent. Forced labor, without pay or at extremely low wages is used as "rehabilitation," with detainees punished if work quotas are not met. People in places of detention are frequently unable to access drug dependence treatment, such as opiate agonist treatment. Withholding of drugs in places of detention, from people who need them for medical purposes, including for drug dependence treatment, is considered a form of torture.	Take effective measures to prohibit, prevent, and redress all acts of torture and ill-treatment, including in the context of drug dependence treatment, whether administered in public or private facilities. Promptly investigate allegations of torture and cruel, inhuman, or degrading treatment or punishment by State or non-State actors and prosecute and punish those responsible. Abolish corporal punishment for drug offences where it is in place. Ensure access to essential medicines, including for drug dependence. Ensure that access to health care for people who use or are dependent on drugs and are in places of detention is equivalent to that available in the community. Establish a national system to effectively monitor drug dependence treatment practices and to inspect drug dependence treatment centres, as well as places of detention.

Human right	Common drug-related rights violations faced by people who use drugs	Action to be taken by governments
Freedom of association	In many countries community led organisations of people who use drugs are not permitted to register as civil society organisations or to receive foreign donor funding. This is a violation of the right to freedom of association and negatively impacts on the ability of community led organisations to either provide services for their peers or to effectively engage in the design, implementation and assessment of laws and policies that directly affect them.	Remove all legal barriers to the registration of community led and based organsiations of and for people who use drugs. Remove legal barriers to the receipt of foreign donor funding by community led and based organsiations of and for people who use drugs. Remove legal barriers that unreasonably restrict or prevent the participation of affected individuals and communities in the design, implementation, and assessment of drug laws, policies, and practices. Adopt and implement laws and other measures, including institutional arrangements and mechanisms, to facilitate the participation of affected individuals and groups in the design, implementation, and assessment of drug laws, policies, and practices. Remove laws depriving people of the right to vote as a consequence of drug convictions[22].

22. The full list of recommendations to governments can be found in the International Guidelines On Human Rights And Drug Policy, 2019, UNDP, UNAIDS, WHO and ICHRDP https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy

Unit 5: Bold New Targets: What are they and how do we use these targets for advocacy?

FACILITATORS NOTE:

Duration: 3 hours 30 minutes

Slides to be presented: Slides 30-58

Aim of session: To provide participants information about the new targets and commitments contained in the 2021 Political Declaration on HIV and AIDS by 2030: Ending Inequalities and Getting on Track to End AIDS by 2030, and in the UNAIDS Global AIDS Strategy 2021-2026: End Inequalities. End AIDS and how to use these in their advocacy.

Learning objectives:

- To inform participants about the new targets and commitments contained in the 2021 Political Declaration on HIV and AIDS by 2030: Ending Inequalities and Getting on Track to End AIDS by 2030, and in the UNAIDS Global AIDS Strategy 2021-2026: End Inequalities. End AIDS relevant to people who use drugs
- To provide participants with a better understanding of how to use these targets and commitments in their advocacy.

Steps:

1. Explain the aim of this session
2. Presentation: Present the information to be covered in this session contained in slides 30-58.
3. Activity: Break the participants up into three groups and ask them to discuss which of the targets and commitments speak to specific problems that they experience in their countries, how useful they feel that the targets and commitments will be for them in their advocacy and how they might go about using them. Reconvene the participants, ask each group to share their findings and facilitate a short discussion how the targets and commitments can be used in practice for advocacy.

Important note:

It will be very useful to ask the participants to read through the two documents before coming to the training, particularly on the targets of the Global AIDS Strategy, and the Political Declaration. At the moment, the Global AIDS Strategy is only available in English and Bahasa Indonesia. The Political Declaration is available in English, Arabic, Chinese, French, Russian and Spanish.

Materials Needed

- Projector
- Flipchart and marker pens

INFORMATION TO BE COVERED IN THIS SESSION

5.1 Introduction to the Targets

The adoption in June 2021 by United Nations Member States of a set of new and ambitious targets in a Political Declaration on HIV and AIDS by 2030: Ending Inequalities and Getting on Track to End AIDS by 2030, whilst long overdue, is to be welcomed. The Political Declaration is aligned to the recently adopted bold new UNAIDS Global AIDS Strategy 2021-2026: End Inequalities. End AIDS, which recognises that our failure to adequately address inequalities across multiple forms and dimensions, including those based on HIV status, gender, race, ethnicity, disability, age, income level, education, occupation, geographic disparities, migratory status and incarceration, which often overlap to compound each other, have contributed to our failure to reach the 2020 global HIV targets, and acknowledge that only by reducing these inequalities can we close the gaps for HIV prevention, testing, treatment and support by 2025 and put our countries back on course to end AIDS by 2030.

> Inequalities in the HIV response remain stark and persistent—they block progress toward ending AIDS.
>
> Decades of evidence and experience, synthesised in a comprehensive evidence review undertaken by UNAIDS in 2020, show that inequalities are a key reason why the 2020 global targets were missed. The inequalities that underpin stigma, discrimination and HIV-related criminalisation, enhance people's vulnerability to acquire HIV and make people living with HIV more likely to die of AIDS-related illnesses. The majority of people who are newly infected with HIV and who are not accessing life-saving HIV services are from the key population groups and they live in vulnerable contexts, where inadequate political will, funding and policies prevent their access to health care.
>
> The risk of acquiring HIV is 26 times higher among gay men and other men who have sex with men, 29 times higher among people who inject drugs, 30 times higher for sex workers, and 13 times higher for transgender people. Every week, about 4,500 young women aged 15–24 years acquire HIV. In sub-Saharan Africa, 5 in 6 new infections among adolescents aged 15–19 years are among girls. Young women are twice as likely to be living with HIV than men. Only 53% of children 0–14 years who are living with HIV have access to the HIV treatment that will save their lives.
>
> A central reason why disparities in the HIV response remain so stark and persistent is that we have not successfully addressed the societal and structural factors that increase HIV vulnerability and diminish people's abilities to access and effectively benefit from HIV services. Recognising the equal worth and dignity of every person is not only ethical, it is critical for ending AIDS. Equal access to HIV services and the full protection of human rights must be realised for all people[23].

23. Global AIDS Strategy 2021-2026. End Inequalities. End AIDS, 10-11

The Political Declaration recognises that key populations, including people who inject drugs, are more likely to be exposed to HIV and face violence, stigma, discrimination and laws that restrict their access to HIV prevention and treatment services. It is also important to note that this is for the first time the Political Declaration explicitly mentions people who inject drugs.

Both the Global AIDS Strategy and the Political Declaration set out the following bold new targets to be reached by 2025 if we are to end AIDS as a public health threat by 2030, known as ''the 10-10-10 targets''[24]:

- Ensure that less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025.
- They also committed to ensuring that less than 10% of people living with, at risk of or affected by HIV face stigma and discrimination by 2025; and
- Reducing to no more than 10 % the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence by 2025.

Of particular importance to our community are the six targets[25] that specifically relate to the societal enabler targets for people who use drugs:

- Less than 10% of countries criminalise drug use and possession of small amounts of drugs[26].
- Less than 10% of people who use drugs, report experiencing stigma and discrimination[27].
- Less than 10% of people who use drugs lack access to legal services[28].
- Less than 10% of people who use drugs experience physical or sexual violence[29].
- Less than 10% of countries lack mechanisms for people living with HIV and key populations to report abuse and discrimination and seek redress.
- Less than 10% of health workers report negative attitudes towards key populations
- Less than 10% of law enforcement officers report negative attitudes towards key populations

24. Political Declaration para 63(e) and 65(a) and (e); Global AIDS Strategy 61-62
25. Political Declaration para 65(a) and (e); Global AIDS Strategy 138
26. See para 65(a): Creating an enabling legal environment by reviewing and reforming, as needed, restrictive legal and policy frameworks, including discriminatory laws and practices that create barriers or reinforce stigma and discrimination such as age of consent laws and laws related to HIV non-disclosure, exposure and transmission, those that impose HIV-related travel restrictions and mandatory testing and laws that unfairly target people living with, at risk of and affected by HIV, with the aim of ensuring that less than 10 per cent of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025;
27. See Para 65(e): Working towards the vision of zero stigma toward and discrimination against people living with, at risk of and affected by HIV, by ensuring that less than 10 per cent experience stigma and discrimination by 2025, including by leveraging the potential of Undetectable = Untransmittable;
28. See Para 67(b): Investing in robust, resilient, equitable and publicly funded systems for health and social protection systems that provide 90 per cent of people living with, at risk of and affected by HIV with people-centred and context-specific integrated services for HIV and other communicable diseases, non-communicable diseases, sexual and reproductive health care and gender-based violence, mental health, palliative care, treatment of alcohol dependence and drug use, legal services and other services they need for their overall health and wellbeing by 2025;
29. See Para 63(e): Reducing to no more than 10 per cent the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence by 2025

In addition, both the Global AIDS Strategy[30] and the Political Declaration[31] recognise the importance of community-led responses to HIV and have set the following targets, known as "the 30-60-80 targets", to ensure that the community is at the front and centre of the HIV response for people who use drugs:

- 30% of testing and treatment services to be delivered by community-led organisations.
- 60% of the programmes to support the achievement of societal enablers to be delivered by community-led organisations.
- 80% of service delivery for HIV prevention programmes for people who use drugs to be delivered by community-led organisations.

Definitions: Community led organsations and community-led responses: What are they[32]?

Community-led organisations, groups and networks, whether formally or informally organised, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organisations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organisations are community led

Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organisations, groups and networks that represent them.

The Global AIDS Strategy recognises that communities living with or affected by HIV must lead the way get the response on-track to end AIDS by 2030. Community-led responses are really important as they are determined by and respond to the needs and aspirations of their communities. Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organizations, groups, and networks.[33] Communities give voice to people who are often excluded from decision-making processes.

Progress in recent years demonstrates the essential role of community-led HIV responses in global efforts to end AIDS. As of 2019, community and key population-led HIV prevention programmes that exceeded 80% coverage in many countries were among the most effective[34].

30. Global AIDS Strategy 63
31. Political Declaration para 64
32. https://www.unaids.org/sites/default/files/media_asset/PCB51_MTT_report__CLR.pdf page 33 in footnote 10.
33. ibid
34. Global AIDS Strategy, p63

Despite the importance and effectiveness of community-led responses, community-led organisations continue to face challenges, legal and administrative barriers, exclusions, and severe lack of funding and investment, particularly organisations led by key populations, including people who use drugs.

This recognition, unlike the 10-10-10 targets, is not new in the global HIV response. The 2016 Political Declaration committed to invest from the total AIDS resources a minimum of a quarter for HIV prevention, 30% for community-led services, and 6% for social enablers[35]. In 2020, a report by Aidsfonds highlighted the severe lack of funding for key population programmes at only 2% of the total HIV expenditures in low- and middle-income countries[36]. Furthermore, audits of Global Fund grants in Indonesia, Nepal, South Africa and Ukraine found that investments have not been paying enough attention towards reaching key populations[37].

Definitions of ''community-led'' used by various development partners differ. For example, UNAIDS defines ''community-led'' as being where the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and have transparent mechanisms of accountability to their constituencies and as being self-determining and autonomous, and not influenced by government, commercial, or donor agendas. It specifically states that not all community-based organisations are community-led. PEPFAR, on the other hand, defines ''community-led'' in the context of community-led monitoring (CLM) as ''initiated and implemented by local community-based organisations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups, or other community entities that gather quantitative and qualitative data about HIV services''[38]. PEPFAR thus defines community-led organisations more broadly than UNAIDS. This is important as it means that unless the definitions are standard and in line with the UNAIDS definition, responses that are not necessarily ''community-led'' will be counted in measuring progress towards the 30-60-80 targets. In addition, governments often self-define who and who does not qualify as community-led organisations, thereby exacerbating this problem. Similarly, the newly adopted strategy of the Global Fund for 2023-2027 includes a very strong objective on strengthening community-led programmes. This however is not accompanied with clear definitions and technical guidance to implementers. The current Guidelines on Implementers only specifies general eligibility requirements to be local and legal entity from the public, private and civil society sector, and international organisations in exceptional cases.

The severe lack of investment to community and key population-led organisations has resulted in there being huge disparities between community-led and other civil society organisations in

35. 2016 Political Declaration on HIV and AIDS, para 62(g), 60(d), 64(a) https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS
36. source: Aidsfonds (2020). Fast-Track or Off Track? How insufficient funding for key populations jeopardises ending AIDS by 2030. Available at https://aidsfonds.org/resource/fast-track-or-off-track-how-insufficient-funding-for-key-populations-jeopardises-ending-aids-by-2030
37. See https://www.theglobalfund.org/en/oig/reports/
38. https://www.state.gov/wp-content/uploads/2020/07/PEPFAR_Community-Led-Monitoring_Fact-Sheet_2020.pdf

terms of both programmatic and organsiational management knowledge, skills, and capacity. One of the primary causes of this underfunding is the fact that many donor requirements are often unrealistic for community-led organsiations, making it impossible for them to compete with other civil society organisations for funding. These requirements often apply to any contexts, even in the countries where organisations led by people who use drugs are prohibited and unable to register formally.

It is thus critical that organisations led by people who use drugs advocate for sufficient funding for their organisations in order for the 30:60:80 targets to be met.

Definition of key populations and key population-led organisations[39]

Key population-led organisations and networks are entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives and voices of their constituencies. For reporting on these indicators, the focus is on key population-led organisations and networks that are defined as being led by the following groups: female, male and transgender sex workers; gay men and other men who have sex with men; people who use drugs, including women who use drugs; and transgender people.

In the Political Declaration, the Member States also committed to increase and fully fund the AIDS response. They agreed to invest US$ 29 billion annually by 2025 in low- and middle-income countries. This includes investing at least US$ 3.1 billion towards societal enablers, including the protection of human rights, reduction of stigma and discrimination and law reform.

The Political Declaration contains significant commitments on specific areas that are relevant to the community of people who use drugs. It is crucial for the community to build on the opportunities that the Political Declaration offers, hold governments accountable, and strengthen advocacy initiatives at various levels in their respective countries and regions.

5.2 How can we use the targets and commitments contained in the Political Declaration?

The 2021 Political Declaration contains significant commitments made by our countries[40] on specific areas that are relevant to the community of people who use drugs. Although this Political Declaration was adopted at the global level it is important for all of us in our own countries as, with the exception of the Russian Federation, Belarus, Nicaragua and the Syrian Arab Republic, the majority of all of our countries have signed up to these commitments and targets and can and should be held accountable for ensuring that these commitments and targets are

39. UNAIDS Global AIDS Monitoring Framework 2022-2026, p34 at https://www.unaids.org/sites/default/files/media_asset/UNAIDS_GAM_Framework_2022_EN.pdf
40. For the first time in UN history the resolution to adopt the Political Declaration was not unanimous and was put to the vote at the request of the Russian Federation, which broke the consensus on issues related to human rights, harm reduction and law reform. Of the 193 voting members, 165 member states voted for, four against, i.e. the Russian Federation, Belarus, Nicaragua and the Syrian Arab Republic, and 24 did not vote. To see the countries that voted for the Political Declaration visit https://digitallibrary.un.org/record/3928346?ln=en

met. It is crucial for the community to build on the opportunities that the Political Declaration offers, hold governments accountable, and strengthen advocacy initiatives at various levels in our respective countries and regions.to ensure that the commitments and targets are met.

This section highlights some of the commitments made and targets set in the document which are of particular importance for people who use drugs as well as the current mechanism used by UNAIDS and governments to measure progress towards the achievement of these commitments and targets (the Global AIDS Monitoring Indicators[41]). It also contains suggested ways in which we can use the commitments to take our advocacy work forward as well as to strengthen our role in monitoring the accountability of governments and other relevant stakeholders.

5.2.1 Human Rights

The Political Declaration contains multiple references to human rights and rights-based approaches throughout the document. This includes:

- Commitment to ensuring that less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025 (Para 65a)
- Commitment to adopt and enforce legislation, policies, and practices that prevent violence and other rights violations against people living with, at risk of, and affected by HIV and protect their rights (Para 65b)
- Secure access to justice for people living with, at risk of, and affected by HIV through establishment of legal literacy programmes, increase access to legal support and representation, expand sensitisation training for judges, law enforcement, healthcare workers, social workers, and other duty bearers (Para 65d)

Member States committed to reform discriminatory laws against people at risk of and living with HIV, including:

- Commitment to creating an enabling legal environment by reviewing and reforming, as needed, restrictive legal and policy frameworks including discriminatory laws and practices (Para 65a)
    - Includes the significant, specific target for creating enabling legal environments "with the aim of ensuring that less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025" (Para 65a)

In addition, the Global AIDS Strategy, which was adopted by a unanimous decision of the UNAIDS Programme Coordinating Board[42], has as a specific target the reduction in the number of countries that criminalise possession of small amounts of drugs to less than 10% by 2025.[43]

41. https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf
42. The countries represented on the UNAIDS Programme Coordinating Board at the time of the adoption of the Global AIDS Strategy were Liberia, Tunisia, Cameroon, Namibia, Kenya, China, India, Japan, Thailand, Iran, Russia, Belarus, Brazil, Guyana, El Salvador, Denmark, Canada, Germany, Luxemburg, Switzerland, UK and USA: https://www.unaids.org/sites/default/files/media_asset/PCB_Membership96-2024_EN.pdf
43. Global AIDS Strategy p 138

What we can do:

- ✔ *Develop clear and consistent advocacy strategies based on the commitments made and signed by our governments*
- ✔ *Consider using human rights mechanisms to advance the rights mentioned in this Declaration and build a stronger case to take forward advocacy efforts*
- ✔ *Work with other key populations and allies to advocate for the protection of our human rights, including through lobbying and campaigning*
- ✔ *Continue to advocate and lobby for the reform of laws that criminalise and punish people who use drugs and other key populations*
- ✔ *Advocate for use of drugs for personal consumption and possession of small amounts to not be considered as either a criminal or administrative offence. It is a challenging task, but we need to work collectively on this and push for full decriminalisation*

All models of decriminalisation **must fully decriminalise** people who use drugs, including: the removal of all administrative sanctions and mechanisms of monitoring, surveillance, coercion and punishment for use and possession of drugs; removing the use of arbitrary quantity thresholds or threshold amounts that result in criminal records; ensuring that operational police fully understand policy and legislative changes associated with full decriminalisation; and establishing independent and ongoing monitoring for criminal justice systems[44].

- ✔ *Work, if possible, with law enforcement agencies to make them understand that people who use drugs may need health services and not punitive action/punishment. Examples of good outcomes of working closely with law enforcement agencies include instances of police personnel referring people who use drugs voluntarily to harm reduction services, or of seeking opiate agonist treatment or overdose (OD) management services for people who use drugs in their custody*
- ✔ *Advocate with law enforcement agencies not to arrest community members for carrying injecting equipment, naloxone, and other life-saving tools availed from drop-in-centers/ community-led outreach services delivery*
- ✔ *Strongly argue and advocate that people who inject drugs, regardless of HIV status and those in prison and other closed settings, must be able to access harm reduction services, most importantly Needle Syringe Programmes (NSP) and Opioid Agonist Treatment (OAT) to prevent and halt further transmission of HIV.*

44. INPUD, Drug Decriminalisation: Progress or Political Red Herring: https://inpud.net/drug-decriminalisation-progress-or-political-red-herring/43. Global AIDS Strategy p 138

5.2.2 Community leadership

The Political Declaration contains several references to community leadership, community-led responses, and community-led monitoring that can be referred to in your advocacy:

- Commitment to reinforce global, regional, national, and sub-national HIV responses through enhanced engagement with stakeholders including community-led organisations (Para 58)
- Commitment to community-led and community-based services for testing and treatment (Para 61b)
- Ensuring that relevant global, regional, national, and subnational networks and other affected communities are included in decision-making, planning, implementing, and monitoring; and are provided with sufficient technical and financial support (Para 64a)
- Creating and maintaining a safe, open, and enabling environment in which civil society can fully contribute to the implementation of the present declaration (Para 64b)
- Adopting and implementing laws and policies that enable the sustainable financing of people-centred and integrated community responses, including peer-led HIV service delivery, including through social contracting and other public funding mechanisms (Para 64c)
- Supporting monitoring and research by communities, including the scientific community, and ensuring that community-generated data are used to tailor HIV responses to protect the rights and meet the needs of people living with, at risk of, and affected by HIV; (Para 64d)
- Commitment to expanding the delivery of primary health care including through community-based services (Para 67h)
- Commitment to investing in community-based emergency response infrastructure and providing strengthened community ownership during health emergencies (para 67i)
- Establish community and participatory monitoring and evaluation systems (Para 69b)

Of particular importance for our community are the commitments and targets in the Political Declaration for putting people who use drugs at the front and centre of the HIV response for people who use drugs:

- Commitment to increasing the proportion of HIV services delivered by communities including ensuring that, by 2025, community-led organisations deliver:
  - 30% of testing and treatment services
  - 80% of HIV prevention services for key population
  - 60% of programmes to support the achievement of societal enablers (Para 64e)
- Commitment to encouraging the strengthening of peer-led responses and expanding community-based health education and training (Para 64f)

The Global AIDS Strategy 2021-2026 also reflects clear targets on community leadership and it is now possible to measure progress on these targets.[45]

Community-led and community-based organisations

It is crucial to note that community-led organisations (i.e. those led by and for people who inject drugs) are not the same as generic community-based organisations (CBOs). In community-led organisations, power and decision-making lie in the hands of community members—i.e. people who inject drugs—whereas in a CBO (which may be a local affiliate of a national or international NGO), power may reside only with some members of the community, or more commonly, with administrators who are not community members. It is the self-determining and self-governing nature of an organisation, and its commitment to pursue the goals that its own members have agreed upon, that makes it a genuinely community-led organisation.

Please refer to Page 14 of the IDUIT, available here.

UNAIDS defines community-led organisations as entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. They are self-determining and autonomous, and not influenced by government, commercial, or donor agendas.

The Global AIDS Monitoring Framework 2022-2026 defines key population-led organisations and networks as "entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives and voices of their constituencies[46]"

What we can do:

- ✔ *Develop among ourselves a thorough understanding of how community leadership and community-led monitoring can be strengthened. This may include developing consensus on what kind of approach would work best in local contexts; identifying appropriate advocacy strategies and targets; as well as initiating meetings between key population-led networks/community-led organisations and local governments or donors*
- ✔ *Develop and implement capacity building plans for drug user-led network and organisations based on specific areas that need strengthening*
- ✔ *Collectively engage with national and local governments and donors to develop realistic plans and actions for creating and maintaining spaces, forums, and platforms for people who use drugs to be directly involved in policymaking and programme implementation*

45. The Global AIDS Strategy (GAS) 2021-2026. Available at: https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf
46. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_GAM_Framework_2022_EN.pdf

- ✔ *Advocate for and monitor investment of funding and resources for community-led responses and organisations, including strongly pushing for dedicated funding streams for drug user-led networks covering core funding, capacity building, programmes, and advocacy for decriminalisation of drug use*
- ✔ *Ensure clear understanding of the difference between community-based organisations and community-led or key population-led organisations, advocate governments, international development partners, donors, and other stakeholders to consistently use the UNAIDS definitions.*
- ✔ *Ensure that governments use the definition of key population-led organsiations and networks as laid out in the Global AIDS Monitoring Framework: 2022-2026 when reporting on the extent to which services are delivered by community-led or key population-led organisations or networks.*
- ✔ *Advocate for the consistent use of the definition of key population-led organsiations and networks as laid out in the Global AIDS Monitoring Framework: 2022-2026 in all national processes, including Global Fund, PEPFAR and other UN agency processes.*

5.2.3 Stigma and discrimination

The Political Declaration contains multiple references to stigma and discrimination, and commits to:

- Eliminate HIV-related stigma and discrimination through concrete resource investment and development of guidelines and training for healthcare workers (Para 65)
- Expand investment in societal enablers (including protection of human rights, reduction of stigma and discrimination, and law reform) in low- and middle-income countries to 3.1 billion US dollars by 2025 (Para 65c)
- Achieving target for working towards zero stigma: "Commitment to working towards the vision of zero stigma and discrimination against people living with, at risk of and affected by HIV, by ensuring that less than 10% experience stigma and discrimination by 2025" (Para 65e)

What we can do:

- ✔ *Hold governments accountable for fulfilling their commitment towards eliminating stigma and discrimination*
- ✔ *Advocate with governments to sign up to the Global Partnership for Action to end all forms of HIV-related stigma and discrimination as part of their commitment to achieve zero discrimination*

The Global Partnership for Action to end all forms of HIV-related stigma and discrimination was established in 2018 in response to a call by the UNAIDS Programme Coordination Board (PCB) Non-Governmental Organisations (NGO) delegation and UN partners for

stronger efforts to address the negative effects of stigma and discrimination in the lives of people living with and vulnerable to HIV. By raising awareness about these barriers to health and well-being, the Global Partnership aims to inspire countries to take action to understand and confront them. The Global Partnership recognises that the key to ending stigma is the work of communities and civil society leading interventions in six different settings and areas of people's lives: families and communities, workplaces, education, justice systems, health settings, and emergency and humanitarian settings. (See https://www.unaids.org/en/topic/global-partnership-discrimination for more information on the Global Partnership and the list of countries that have joined the Global Partnership.)

- ✔ *Regularly conduct research to generate evidence and data to inform policy and decision makers on the impact of stigma and discrimination, and punitive laws, policies and practices on the rights of people who use drugs.*
- ✔ *Advocate with international development partners and donors to allocate funding to support community-led monitoring on stigma and discrimination and its impact towards people who use drugs.*
- ✔ *Collaborate with governments and stakeholders to develop effective strategies to ensure that less than 10% of key population experience stigma and discrimination targets are met by 2025*
- ✔ *Advocate for review and removal of laws, policies, and practices that present as barriers to achieving the 2025 targets on stigma and discrimination, as well as within the six settings of the Global Partnerships.*

5.2.4 Prevention, Testing and Treatment

The 2021 Political Declaration addresses various aspects of prevention and treatment, including:

- Commitment to harm reduction as part of combination HIV prevention
  - 95% people at risk of HIV have access to and use appropriate, prioritised, person-centred, and effective combination prevention by 2025 (Para 60a).

Note: UNAIDS defines combination prevention as "rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infection."[47] Harm reduction services are also included as an essential part of combination HIV prevention packages.

- Commitment to tailor combination prevention approaches to meet the diverse needs of key populations, including people who inject drugs (para 60b)

47. UNAIDS, 2010. Combination HIV Prevention: *Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections.*

- Commitment to achieve the 95–95–95 testing, treatment, and viral suppression targets within all demographics and groups and geographic settings, ensuring that, by 2025, at least 34 million people living with HIV have access to medicines, treatment, and diagnostics (para 61)
- Provide 90% of people living with, at risk of, and affected by HIV with people-centred and context-specific integrated services for HIV and other communicable diseases, non-communicable diseases, sexual and reproductive health (SRH) care and gender-based violence, mental health, palliative care, treatment of alcohol dependence and drug use, legal services, and other services they need for their overall health and well-being by 2025 (para 67b)
- Reduce the high rates of HIV coinfection with tuberculosis, hepatitis C, and sexually transmitted infections, including the human papillomavirus and hepatitis B (para 67c)

5.2.4.1 Harm reduction as part of combination prevention

The Declaration talks about harm reduction in stronger terms as compared to earlier HIV/AIDS Declarations. References that can be used in your advocacy include the following:

- Definition of the comprehensive package of nine interventions included as a footnote to paragraph 36: "A comprehensive package for the prevention, treatment and care of HIV among intravenous drug users should include the following nine interventions: (i) needle and syringe programmes; (ii) opioid substitution therapy and other drug dependence treatment; (iii) HIV testing and counselling; (iv) antiretroviral therapy; (v) prevention and treatment of sexually transmitted infections; (vi) condom programmes for intravenous drug users and their sexual partners; (vii) targeted information, education and communication for intravenous drug users and their sexual partners; (viii) vaccination, diagnosis and treatment of viral hepatitis; and (ix) prevention, diagnosis and treatment of tuberculosis''. (This is the first time that any Political Declaration has specifically listed harm reduction interventions, and in doing so, given them due recognition)
- Note that the majority of countries and regions have not made significant progress in expanding harm reduction programmes and relevant interventions that prevent HIV, viral hepatitis, and other blood-borne diseases associated with drug use (Para 37)

Although the Declaration does not include specific targets on harm reduction interventions, these can be found on page 132 of the Global AIDS Strategy (GAS) 2021-2026. These are 90% coverage of needles and syringe programmes (NSP) and 50% coverage of opiate agonist treatment by 2025.

It is also important for us to understand that when it comes to service coverage targets, the quality of existing data on size estimates is critical. Having inaccurately low or outdated estimates of people who inject drugs may result in services only cover a small proportion of the actual size as well as a smaller proportion of funding allocated for services for people who inject drugs. Of the 193 countries that signed the 2021 Political Declaration on HIV and AIDS, only 90 countries

have population size estimates for people who inject drugs.[48] Even where estimates do exist, there is limited evidence of sustained uptake of these data to guide the HIV responses.[49]

What we can do:

- ✔ *Advocate the government, international development partners and donors to review and update the population size estimates of people who inject drugs, ensuring involvement of people who use drugs throughout the process.*
- ✔ *Lobby and dialogue with governments on making progress on meeting the 2025 HIV prevention and treatment targets through scaling-up and expanding harm reduction services*
- ✔ *Build up awareness on the 2025 harm reduction, testing, and treatment targets amongst the community of people who use drugs.*
- ✔ *Advocate for involvement of people who use drugs in developing, delivering, and monitoring and evaluation of combination prevention approaches for countries.*
- ✔ *Advocate for the removal of all laws, policy, and practices that present as barriers to the availability, accessibility, and affordability of combination prevention services for people who use drugs.*
- ✔ *Scale up advocacy and education on hepatitis C prevention, testing, and treatment.*
- ✔ *Advocate for greater discussion, education, and training within drug user-led networks about the available evidence in relation to pre-exposure prophylaxis (PrEP) and people who inject drugs, to identify what is known where further research is needed and what constitutes best practice in relation to PrEP and people who inject drugs.[50]*
- ✔ *Advocate with our governments to scale up harm reduction services, using the 90% NSP and 50% OAT targets, and to ensure these targets are included in the National Strategic Plan.*
- ✔ *In situations where harm reduction services are not yet initiated, we should call on governments and donors to start harm reduction services and ensure that the prescribed WHO and UNAIDS comprehensive harm reduction guidelines (available here) are adhered to (Note: a revised version of the WHO/UNAIDS comprehensive harm reduction guidelines will be launched in July/August 2022).*
- ✔ *Advocate for meaningful involvement of people who use drugs in the design, implementation, monitoring, and evaluation of services for people who use drugs, using the Injecting Drug User Implementation Tool (IDUIT) co-developed by INPUD as reference (available here). This includes services for different age groups and gender-sensitive services.*

48. http://aidsinfo.unaids.org
49. Viswasam N, Lyons CE, MacAllister J, Millett G, Sherwood J, Rao A, et al. (2020) The uptake of population size estimation studies for key populations in guiding HIV responses on the African continent. PLoS ONE 15(2): e0228634. https://doi.org/10.1371/journal.pone.0228634
50. International Network of People who Use Drugs (INPUD), 2021. *INPUD Summary Report: WHO Key Populations' Values & Preferences for HIV, Hepatitis and STIs Services*

5.2.5 Women who use drugs

Commitments related to protecting the rights of women in this Declaration are also absolutely relevant to women who use drugs. These include:

- Commitment to put gender equality and the human rights of all women and girls in diverse situations and conditions at the forefront of efforts to mitigate the risk and impact of HIV (para 63)
- Eliminating sexual and gender-based violence, including intimate partner violence by adopting and enforcing laws, changing harmful gender stereotypes and norms, and providing services to address multiple forms of discrimination and violence against women living with, at risk of, and affected by HIV (para 63d)
- Reducing the number of people who experience gender-based inequalities and sexual and gender-based violence to no more than 10% by 2025 (para 63e)
- Ensuring that 95% of women and girls have HIV and sexual and reproductive health (SRH) service needs met by 2025 (para 63f)

Additionally, the 2021-2026 Global AIDS Strategy also includes a specific target to ensure 80% of services for women including prevention services for women at increased risk to acquire HIV, as well as programmes and services for access to HIV testing, linkage to treatment (ART), adherence and retention support, reduction/elimination of violence against women, reduction/elimination of HIV related stigma and discrimination among women, legal literacy and legal services specific for women-related issues, to be delivered by community-led organisations that are women-led[51].

What we can do:

✔ *Ensure that women in all their diversity (that is women who use drugs, sex workers, and transgender women) are included in definitions and targets related to women*
✔ *Create opportunities for women who use drugs to be more actively engaged in SRH education and addressing gender-based violence*
✔ *Advocate to establish more gender-sensitive harm reduction programming including for pregnant women who use drugs to have access to much needed OAT programmes*
✔ *Ensure that mechanisms to address gender-based violence are in place and accessible by women who use drugs, including prevention, response, and protection mechanisms*
✔ *Collaborate with communities and agencies working on women's rights to ensure that women who use drugs are part of the larger feminist movement to protect their rights*
✔ *Advocate for greater investment in women-led responses and organisations to support and build capacity and leadership*
✔ *Advocate to establish safe space and environment for women who use drugs in key decision-making fora, and ensuring representation of women who use drugs at all levels*

51. 2021-2026 Global AIDS Strategy at p 141

✔ *Advocate to remove all policies and laws that discriminate against women and put them at greater risk and vulnerability of HIV*

5.2.6 Accountability

Member States are committed to mutual accountability mechanisms that are transparent and inclusive, with active involvement of people living with, at risk of, and affected by HIV; and other relevant civil society, academia, and private sector stakeholders, to support the implementation and monitoring of progress on the commitments in this political declaration [see para 59]

Paragraph 70 of the Political Declaration includes Member States commitment to support and leverage the 25 years of experience and expertise of the Joint United Nations Programme on HIV/AIDS and reinforce and expand the unique multisectoral, multi-stakeholder, development and rights-based collaborative approach to end AIDS and deliver health for all as global public good by:

- requesting the Joint Programme to continue to support Member States, within its mandate, in addressing the social, economic, political and structural drivers of the AIDS epidemic, including through the promotion of gender equality and the empowerment of women, and human rights, by strengthening the capacities of national Governments to develop comprehensive national strategies to end AIDS and by advocating for greater global political commitment in responding to the epidemic; (para 70b)
- fully resourcing the Joint Programme and supporting its efforts to refine and reinforce its unique operating model so that it can continue to lead global efforts against AIDS, support efforts for pandemic preparedness and global health; (para 70c)
- anually voluntary reporting to the Joint Programme on progress in the implementation of the commitments contained in the present declaration, using robust monitoring systems and international follow-up and review processes that identify inequality gaps in service coverage and progress in HIV responses, and to inform the General Assembly, the Economic and Social Council and the high level political forum on sustainable development. (para 70d)

Additionally, the last section of the Political Declaration includes the follow up actions in the implementation of the declaration including:

- to report annually to the UN General Assembly on the progress achieved in realising the commitments contained within the present declaration; (para 71)
- to review the progress on the 2025 targets and commitments and agree on modalities for the next high-level meeting on HIV and AIDS in 2026. (para 73)

Targets and commitments in the Political Declaration and the Global AIDS Strategy are measured through a global reporting and monitoring system called the Global AIDS Monitoring (GAM) led by UNAIDS. The 2022-2026 GAM Framework and Indicators should reflect all these targets and commitments. Members States have the obligation to report these data annually,

through it is important to note that it is non-binding and voluntarily. Additionally, national data systems do not often include similar and compatible indicators or countries simply do not have the resources and infrastructure to provide adequate data.

The GAM reporting process is done through specific and fixed cycle and timeline between December of the reporting year and March of the following year. UNAIDS publishes annual Global AIDS Update report in July, following the data gathered through GAM and other sources, The annual Global AIDS Update report has a critical role as it is used to inform programmatic and financial decisions, including by the Global Fund and PEPFAR, as well as by the UN Secretary General to provide annual progress report to the UN General Assembly as mentioned in the Political Declaration paragraph 71.

It is also important to note that by design, the GAM reporting process should involve people from the community, including people who use drugs, especially Part B of the GAM, or better known as the National Commitment and Policy Instruments (NCPI) where it must be completed by the community/key population/civil society. Additionally, the community may also submit a shadow report.

A more detailed information on processes and timeline of the GAM can be found in the 2022 GAM Framework[52].

Global targets and commitments if not reflected in and translated into national action will mean nothing. At the very least, governments should immediately review their targets within the National Strategic Plan on HIV and AIDS and incorporate new targets, commitments and other critical components such as societal enablers and community leadership. The International Guidelines on Human Rights and Drug Policy is a good entry point to engage with the government and start a dialogue on pushing for decriminalisation of drug use.

Additionally, the role of the two largest funders for HIV, the Global Fund and PEPFAR is very important. Specifically for the Global Fund, we have different opportunities to engage through the different processes and spaces, including the CCM, technical working groups, and the Funding Request development process. While opportunities to engage with PEPFAR are fewer, lessons from key population networks in several countries may be a model that can be adapted[53]. In addition to advocating for a dedicated funding stream for networks of people who use drugs, we must also hold the implementers of these grants to account, and to ensure that within their activities and workplan, efforts to achieve decriminalisation of drug use, harm reduction and OAT targets, and funding towards community-led responses, along with other relevant targets in the 10-10-10 and 30-60-80 are included.

52. Available at https://www.unaids.org/sites/default/files/media_asset/UNAIDS_GAM_Framework_2022_EN.pdf
53. See for example the call for increased investment in key-population led programming in the Health Gap/ PEFPAR Watch ''Where is PEPFAR's Strategy for Key Populations? Community Analysis of the Successes and Challenges of PEPFAR's Key Population Programme and Recommendations for the Next PEPFAR Ambassador", at https://healthgap.org/wp-content/uploads/2021/09/PEPFAR-Key-Populations.pdf

What we can do:

- ✔ *If not already reflected, call for the government to review the National Strategic Plan on HIV and AIDS and to incorporate targets and commitments in the 2021-2026 Global AIDS Strategy and the 2021 Political Declaration on HIV and AIDS*
- ✔ *Keep track of accountability and transparency, particularly in terms of budgets committed by government, donors and UN agencies, particularly UNAIDS and relevant UN cosponsoring organisations based on their mandate, such as UNODC, UNDP, UN Women, align with the commitment related to societal enablers and community leadership targets. In case of limited presence of in-country UN offices, refer to the Regional Office of the respective UN entity.*
- ✔ *Request the government, UNAIDS, other UN Cosponsors, and Donors to consolidate the national indicators to be aligned with indicators of the Global AIDS Monitoring with the key population communities, and to ensure that people who use drugs are involved throughout the process including the annual reporting to the GAM.*
- ✔ *Request the government to recognise and use data gathered by the community, including people who use drugs, to complement the national data system, including the population size estimates, routine data collection, qualitative data related to the health outcomes of people who use drugs.*
- ✔ *Advocate and lobby for adequate seats of representations of people who use drugs, including women and young people who use drugs, in key national decision-making spaces, such as the CCM, the formation of Key Population sub-committee of the CCM, technical working groups, national coordination forum, the PEPFAR COP/ROP, the Global Fund Funding Request, etc.; and to ensure safety and security of our involvement and participation, as well as continuous support and capacity building towards people who use drugs to meaningfully participate in these spaces.*
- ✔ *Advocate with Donors and International Development Partners to fund community-led monitoring activities led by people who use drugs to monitor progress towards achieving the 10-10-10 and 30-60-80 targets.*
- ✔ *Advocate and lobby with the government to conduct a comprehensive assessment on the legal and policy environment, using the International Guidelines on Human Rights and Drug Policy as a toolkit to inform the gaps in their human rights obligations related to drug policy.*

Unit 6: Practical Guide to Advocacy

FACILITATORS NOTE

Aim of Unit: To strengthen the capacity of people who use drugs to effectively engage in advocacy on drug policy and barriers to access to HIV and other health services for people who use drugs and to develop an advocacy action plan or roadmap.

Learning outcomes

At the end of this module participants will be able to:

- Define advocacy
- Identify general principles, goals and strategies for effective advocacy
- Develop a comprehensive costed advocacy plan/ roadmap
- Develop methods of monitoring and evaluation of advocacy tools and methods

Materials:

- Projector
- Flip chart and marker pens

Note: In addition to these, handouts will be given to participants in some of the following sessions. Information on the specific handouts required for each session is contained in the Facilitators Note at the beginning of each session. These handouts can either be in the form of photocopies or an electronic version, depending on whether participants have access to laptops.

Session 6.1

Activity: What do we mean by advocacy[54]?

FACILITATORS NOTE:

Duration: 30 minutes

Slides to be presented: Slides 59-61

Aim: To come to a common shared understanding of the term "advocacy"

Steps:

1. Introduce the aim of the session.
2. Ask participants to brainstorm on what we mean by advocacy. Ask participants to share their personal experiences in engaging in advocacy work and provide key words that define advocacy, and note them on a flipchart.

54. Adapted from IDPC Drug Policy Training Toolkit: MODULE 4 Civil society engagement in drug policy advocacy

3. Ask participants to also brainstorm on different types of advocacy activities, drawing on their personal experience in engaging in advocacy and note them on a separate flipchart.
4. Present the advocacy definition and the key characteristics as well as the different types of advocacy activities on slides 60 and 61 and lead a brief discussion on how these fit with the participants' inputs.

INFORMATION TO BE COVERED IN THIS SESSION (SLIDES 60-61)

Advocacy means working for change - it can be used to push for change in government laws or policies, as a tool to influence change in public attitudes or media discourse, or as a means to educate and engage the public or key decision makers on the need for change. The most obvious ultimate change that drug user activists working to end the criminalisation of drug use want to see is the repeal of laws that prohibit drug possession and use. Achieving this change is however not easy as laws that criminalise drug possession and use are intricately linked with public opinion and dominant social norms in each country which, despite the best advocacy efforts, take time to change. We know that law reform is a long process that can take years. When planning and engaging in advocacy for drug law reform we need to plan for a range of incremental advocacy approaches and goals that support both direct advocacy for law reform as well as advocacy that seeks to limit the immediate harms caused by the criminalisation of drug use whilst we work towards the longer-term goal of law reform.

There are many different types of advocacy activities. Some of the most common include:

- Speaking directly (lobbying) to decision-makers to persuade them to change laws, policies and programmes
- Taking mass action (e.g. going on a march or demonstration) to challenge decision-makers to solve a problem
- Bringing court cases to challenge laws and policies or to make decision-makers comply with human rights obligations
- Using the media to put pressure on decision-makers to make changes to laws and policies – this is sometimes called naming and shaming because its success as a strategy relies on publicly shaming decision-makers who are resistant to change
- Raising awareness about problems and educating people living with HIV and key populations so that they can take actions to enforce their rights
- Documenting human rights abuses to persuade decision-makers of the need for changes.

These actions are discussed in more detail in the next section of this unit.

Session 6.2

Activity: Guiding Principles For Advocacy

FACILITATORS NOTE:

Duration: 20 minutes

Slides to be presented: Slide 62

Aim: To understand the guiding principles that should underpin all human rights advocacy

Steps: Introduce the aim of the session.

1. Present the guiding principles on slide 62 and lead a brief discussion on why these guiding principles are so important.
2. Ask participants to share examples of successful community-led advocacy in their country.

INFORMATION TO BE COVERED IN THIS SESSION (SLIDE 62)

Two key principles should guide every stage of human rights advocacy: ''communities at the centre'' and "do no harm".

Communities at the Centre

For many years, people who inject or otherwise use drugs have been proactive in protecting their health, fighting for their rights and supporting active, caring and committed communities. Organisations led by people who use drugs have played a central and creative role in fighting for their rights, even in the most repressive environments. Community empowerment has been key to this success. Community empowerment refers to a process of enabling groups or communities of people to increase control over their lives. It means more than the involvement, participation or engagement of communities in pre-existing or new programmes: it implies community ownership, and action that explicitly aims at social and political change. Community empowerment addresses the social, cultural, political and economic determinants that affect health and seeks to build partnerships with other sectors in finding solutions.

There have been many successful partnerships between communities of people who use drugs and other actors—such as researchers, lawyers and advocates, and service-providers who are not from communities of people who use drugs—that have led to the attainment of common goals. The most noteworthy and efficacious programmes are those that acknowledge and support community and drug user leadership and empowerment as a key principle and practice. For more on community empowerment and participation see INPUD's Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions here.

Do No Harm

Before considering the various advocacy approaches to use it is important to assess the impact that the advocacy will have on the physical safety, freedom and well-being of those who engage in the advocacy including people who use drugs, witnesses, allies, and colleagues. To minimise risk of harm, activists should conduct a risk assessment when devising an advocacy strategy and ensure that everyone involved is aware of the potential risks of harm and to exercise good judgment, caution and sensitivity in all their interactions. It is essential to balance the needs and aims of advocacy with the potential risk of harm, always prioritising the safety of those involved. For example, if interviewing. Providing security information and training should be at the forefront of all advocacy planning, with a focus on physical security, digital security and self-care. All three of these elements are crucial for safety and all activists should take steps to ensure they are able to carry out their work without compromising them (See https://www.careemergency-toolkit.org/topics-issues/2-advocacy/8-criteria-for-deciding-to-engage-in-advocacy/8-2-assessing-risks-of-advocacy/ for an example of how to conduct a risk assessment).

Session 6.3

Activity: An introduction to planning for advocacy

FACILITATORS NOTE:

Duration: 20 minutes

Slides to be presented: Slides 63-66

Aim: To understand the planning process needed for effective advocacy

Steps:

1. Introduce the aim of the session
2. Provide participants with Handout 1: Advocacy Planning Framework
3. Present the introduction to planning for advocacy on slides 63-66

INFORMATION TO BE COVERED IN THIS SESSION (SLIDES 63-66)

Before engaging in advocacy it is important to understand the basics about good advocacy planning. Creating an advocacy plan, understanding your agenda and developing targeted strategies for change will help keep you on track and have greater impact.

Advocacy planning framework

Step 1 Select an issue or problem you want to address

Step 2 Analyse and research the issue / problem

Step 3 Develop specific objectives for your advocacy work

Step 4 Identify your targets

Step 5 Identify your allies

Step 6 Identify the types of advocacy activities for your work

Step 7 Identify your resources

Step 8 Create an action plan

Step 9 Implement, monitor and evaluate

An advocacy plan is a systematic way to define, test and reach agreement on the key elements of your advocacy programme. It helps you to answer questions about which issues you want to address, who you are trying to convince or persuade, what your key messages are and what strategies you think are most likely to lead to change. An advocacy plan should be flexible and responsive to any changes in the environment and allow you to take advantage of new circumstances or opportunities as they arise.

Definition: What is an advocacy plan?

An advocacy plan is a plan of action that considers:

- what the problem is
- what change you want to bring about to deal with the problem
- how best to bring about this change.

An advocacy plan starts with defining the problems and deciding what problem you want to take on. Typically, there will be many issues that you could address, and it will be important to narrow your focus on what you think are the most important issues. The Political Declaration 10:10:10 targets provide you with an ideal opportunity to strengthen your community-led advocacy efforts for decriminalisation. The Political Declaration contains a specific commitment to ensuring that less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025 (Para 65a). In addition, the Global AIDS Strategy, which was adopted by a unanimous decision of the UNAIDS Programme Coordinating Board[55], has as a specific target the reduction in the number of countries that criminalise possession of small amounts of drugs to less than 10% by 2025.[56]

In addition, the Political Declaration contains commitment and targets for putting people who use drugs at the front and centre of the HIV response for people who use drugs:

- Commitment to increasing the proportion of HIV services delivered by communities including ensuring that, by 2025, community-led organisations deliver:
  - 30% of testing and treatment services
  - 80% of HIV prevention services
  - 60% of programmes to support the achievement of societal enablers, including advocacy for decriminalisation (Para 64e)
- Commitment to encouraging the strengthening of peer-led responses and expanding community-based health education and training (Para 64f)

55 The countries represented on the UNAIDS Programme Coordinating Board at the time of the adoption of the Global AIDS Strategy were Liberia, Tunisia, Cameroon, Namibia, Kenya, China, India, Japan, Thailand, Iran, Russia, Belarus, Brazil, Guyana, El Salvador, Denmark, Canada, Germany, Luxemburg, Switzerland, UK and USA: https://www.unaids.org/sites/default/files/media_asset/PCB_Membership96-2024_EN.pdf

56 Global AIDS Strategy p 138

The more you understand about the issue, the better placed you will be to decide how to undertake impactful advocacy. Once you have decided on the issue that you want to focus on, you need to develop some advocacy goals – these are things that you want to achieve and can include longer terms goals such as decriminalisation of possession of small amounts of drugs and/or shorter term goals such as getting the government to put a harm reduction plan in place or making sure that people who use drugs are included in the national response to HIV in your country.

Key questions to ask when setting your advocacy agenda:	**Potential answers**
• What exactly is the problem?	People who use drugs cannot access clean needles and syringes
• Why do we have the problem?	The law makes possession of drug injecting paraphernalia illegal
• Who is affected by the problem?	People who use drugs, their sexual partners
• How are they affected?	The law increases the vulnerability of HIV and other blood borne infections among people who inject drugs and their sexual partners. Needles and syringes are bought from the black market, thus there is no quality assurance of the product.
• What can help to solve the problem?	Setting up needle and syringe programmes accessible to people who use drugs
• What blocks us from solving the problem?	The law that criminalises possession of drug injecting paraphernalia
• What is the goal?	To ensure that people who use drugs have access to clean needles and syringes
• What change do you want to effect to address the problem?	Repeal the law that criminalises possession of drug injecting paraphernalia

The guidance below sets out issues that need to be addressed as you work on your advocacy agenda.

Guideline: Setting an advocacy agenda

- Select the problem you want to address
- Examine and research the problem in detail
- Identify the main issues
- Identify the goals to address these issues.

Session 6.4

Activity: Step 1: Selecting the issue or problem you want to address[57]

FACILITATORS NOTE:

Duration: 30 minutes

Slides to be presented: Slides 67-69

Aim: To select an appropriate and realistic advocacy issue or problem

Steps:

1. Introduce the aim of the session.
2. Provide participants with Handout 2: The Problem Tree and Handout 3: Advocacy Plan / Roadmap Template
3. Split the participants into three groups (either in a random manner, or if you know the participants well enough, assign them in groups to ensure variety of skills and level of knowledge – ensure that people from the same organisations do not end up in the same group).
4. Explain to the group that they will remain in the same groups for the rest of the workshop and ask them to save their work from this session and the following sessions as with the work that they will be doing in this and the following sessions they will be progressively building their advocacy plan or roadmap.
5. Explain to the groups that they each will choose an issue on which they would like to focus their advocacy work.
6. Ask each group to brainstorm a number of drug policy issues that they face in their country that could be addressed through advocacy.. Some of these may be issues that will take some time to resolve (such as decriminalisation) whereas others may be issues that can possible be addressed in a shorter period of time (such as the inclusion of the

57 Adapted from *IDPC Drug Policy Training Toolkit: MODULE 4 Civil society engagement in drug policy advocacy and Amnesty International Body Politics Building a Campaign*

10-10-10 targets in the national strategic HIV plan, the development or scale up of harm reduction programmes, closure of compulsory drug treatment centres, community-led provision of naxolone and safe injecting sites)

7. Ask groups to use the problem tree (see below) to help to give them a better understanding of the problem and how its causes and effects interconnect. They can draw their own problem tree on a flipchart. It will also provide a platform to start identifying who holds power and who they should target in our advocacy. Problem-tree analysis can be particularly valuable in terms of providing opportunities for in-depth discussion and debate. The purpose of the tree is to build a comprehensive and realistic picture of the problem and what is happening on the ground. It will ensure that our understanding of the problem truly reflects the experiences of people most affected and helps build a shared sense of understanding and purpose between partners.

Ask each group to consider the following questions in the course of their discussion:

- What are you trying to achieve? What is your final aim or goal?
- What barriers or problems do you face in your work? Which barriers or problems could be overcome by advocacy?

Stage 1

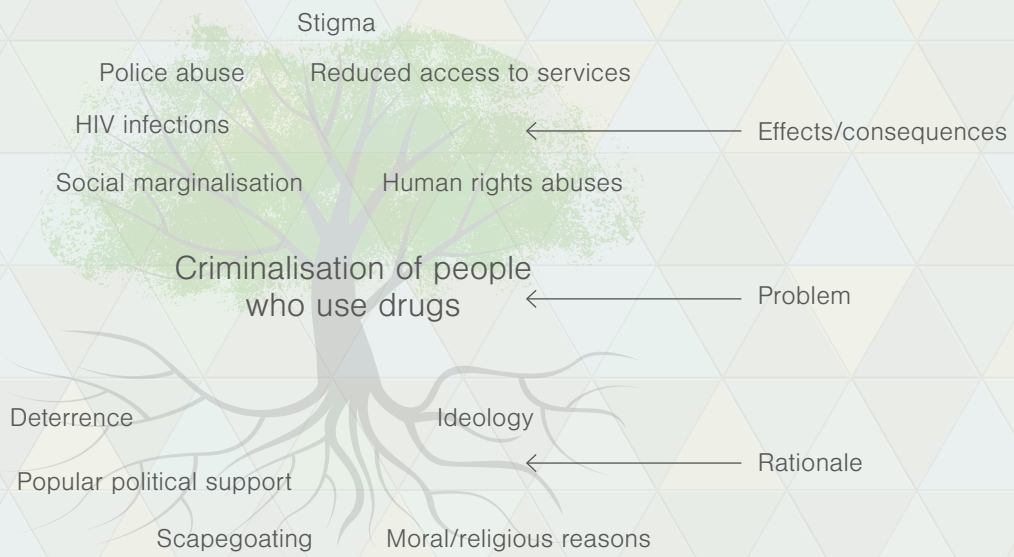
The first stage of problem-tree analysis is discussing and agreeing on the problem to be analysed. This will become the "trunk" of the tree. In the example below, we have used the broad problem of criminalisation of drug use, which will take a while to solve. However, it is possible to apply a narrower shorter-term focus by concentrating on a single issue, such as the lack of access to harm reduction services, lack of access to legal services for people who use drugs, or stigma and discrimination faced by people who use drugs at the hands of law enforcement or health care providers.

Stage 2

The second stage of our analysis is discussing and identifying the causes of the problem. These will become the "roots" of our tree.

Stage 3

In the final stage of analysis we need to discuss and identify the effects of the problem. This section will become the "branches" of the tree. This will help us to think beyond the immediate impact of criminalisation and explore the wider implications that lead to a broad range of human rights abuses and violations.



8. When the groups have made a list of possible issues, ask them to select the best one for advocacy. They can rank issues using the following criteria:
   - To what extent can this issue be solved by advocacy?
   - How many people will benefit from the change?
   - Is the potential for success realistic?
   - Can people directly affected by the issue be involved in the advocacy work?
   - What are the personal / organisational risks associated with the change?

Materials:
Handouts 2 and 3

Session 6.5

Activity: Step 2: Researching and analysing the problem

FACILITATORS NOTE:

Duration: 30 minutes

Slides to be presented: Slides 70

Aim: To understand the need to research and analyse the advocacy issue or problem that you have selected

Steps:

1. Introduce the aim of the session..
2. Present the information on the importance of research and analysis of the advocacy

issue or problem on slides 70

3. Ask the groups to go back to their problem tree, and identify existing research and studies related to the issues, and whether there are other areas that require further research?

Information to be covered in this session (Slides 70)

Once you have identified the problem, it is important to examine and research it as closely as you can and break it down into smaller components. This process can involve in-depth discussions with people who use drugs about their experiences, especially about how their rights have been abused as a result of the problem; consultations with experts such as health care workers, lawyers, academics and policy makers as well as background research to discover as much as you can about the different aspects of the problem e.g. how other countries have dealt with a similar problem.

Why is this research important?

- It helps you better understand the causes and impact of the problem
- It helps you plan your key advocacy messages
- It gives your advocacy credibility because you will be identified as an expert voice on the issue
- It strengthens your arguments with policy makers
- It can help build alliances and coalitions across different groups and organisations.

At the end of this process, you should aim to have a clear understanding of the different dimensions of the problem and which ones your organisation is going to address.

Session 6.6

Activity: Step 3: Developing aims and objectives for your advocacy work

Facilitators Note

Duration: 30 minutes

Slides to be presented: Slides 71-75

Aim: To develop an advocacy aim and objectives

Steps:

1. Introduce the aim of the session.
2. Provide each group with a copy of Handouts 4 and 5
3. Present the guidance on writing advocacy objectives on slides 71-75
4. Ask the groups to write their chosen advocacy aim/goal on flipchart paper.
5. Next, ask the groups to write detailed objective(s) for their advocacy work which describe

how they will achieve their overall aim, making sure that they:

- include the policy, practice or law that they want to change
- include the influential individual, group or institution they are targeting
- write SMART objectives.

Materials:
Handouts 4 and 5 

Note to facilitator: As we will be developing a five-year advocacy plan or roadmap, remind the participants that they can select one long term advocacy aim/goal and one or more medium- and short-term advocacy aims/goals.

Information to be covered in this session (Slides 71-75)

Once you have identified the problem that you want to address, the next step in the process is to identify the aspects of the problem where you believe change can realistically be achieved. This will ensure that your campaigning resources and activities remain focused. When identifying the areas you want to work on it is important to consider:

- What are the most urgent needs of people who use drugs?
- Do the proposed solutions offer a more immediate benefit for those most affected?
- What solutions could be more influential than others in solving the problem?
- Does working on one part of the problem have a detrimental impact on another part?

It is important to have a clear vision of what you want to achieve with our advocacy. This can help you to decide what changes are necessary to reach a solution that will solve (or at least improve) the issue or problem you have identified. Planning advocacy work is similar to planning other activities – it is easier to plan appropriate activities if you first identify aims (or goals) and objectives.

You need to understand the difference between an aim (or goal), objectives and activities:

Aim /Goal: The long-term result that you are seeking to achieve (e.g full decriminalisation of drug use)

Objective: A short term target that contributes toward achieving the long-term aim; objectives describe the desired outcome or end result of activities (e.g. increased awareness and understanding on the part of lawmakers of the human rights imperatives and public health benefits of decriminalisation of drug use)

Activities /Strategy: The individual activities that will accomplish the objectives (e.g. organising sensitisation sessions with lawmakers, identifying a champion for decriminalisation of drug use from amongst lawmakers)

Once you have isolated your aim or goal, it is important to use the SMART (Specific/strategic, Measurable, Achievable, Realistic, Time-bound) criteria to assess their strengths. The table below demonstrates some of the questions that can help you assess your chosen aims.

Smart questions	
Specific / strategic	✔ Are the short-term aims you have chosen well defined? ✔ Can they be understood? ✔ Are there clear actions that could be taken to achieve them? ✔ Are they significant enough to achieve the longer term goal? ✔ Could choosing this aim cause difficulties in other areas?
Measurable	✔ How will you know when the aim has been achieved? ✔ What evidence will be needed to confirm it? ✔ How will you measure success?
Achievable	✔ Do you have the capacity and expertise to achieve the aim? ✔ Will you have enough resources?
Realistic	✔ Can you realistically achieve your aim or goal in the given time period? ✔ Is it realistic to achieve given the socio-political context? For example if a new country leader with strong conservative party support and previous record of human rights violations has recently been elected. ✔ Is it realistic to achieve with the current resources we have, including access to funding, capacity of human resources, etc.?
Time-bound	✔ When should your advocacy come to an end? ✔ Does this give you enough time to achieve your aim? ✔ If you have chosen a number of issues to work on, in what order do they need to be addressed? ✔ Do they need to happen by a certain point in your advocacy?

Aims or goals of advocacy can also be short-term and longer-term goals. We know that law reform is a long process that can take years. When planning and engaging in advocacy for drug law reform you need to plan for a range of incremental advocacy approaches and goals that support both direct advocacy for law reform to achieve the 10:10:10 targets as well as advocacy that seeks to limit the immediate harms caused by the criminalisation of drug use whilst you work towards the longer-term goal of law reform).

You may thus find yourselves simultaneously engaging in advocacy actions or campaigns to achieve both longer term goals such as decriminalisation of drug use and shorter-term goals such as increased access to justice for people who use drugs through expanded peer paralegal programmes or reform of laws that criminalise the possession of needles. It is important to remember that each advocacy campaign or action, whether to achieve longer term or shorter-term goals, needs a goal, an objective and a strategy.

Examples of advocacy aims / goals:

- At the UN level – this could be mobilising member state representatives to call for the removal of all criminal and punitive sanctions against people who use drugs
- At the regional level – this could be ensuring a balanced approach on drug control that includes a strong public health component
- At the local / national level – this could be a longer-term goal of decriminalisation of drug use or a shorter-term goal of decriminalising the possession of needles in order to facilitate the operation of needle and syringe programmes.

Session 6.7

Activity: Step 4: Identifying our advocacy targets

FACILITATORS NOTE

Duration: 30 minutes

Slides to be presented: Slides 76-78

Aim: To identify your primary and secondary advocacy targets

Steps:

1. Introduce the aim of the session
2. Present the guidance on identifying advocacy targets on slides 76-78
3. Provide each group with a copy of Handout 6
4. Ask participants to complete an advocacy targets table using the example below, which is also in Handout 6:

Primary advocacy targets	**Benefits/ drawbacks in approaching them directly**	**(1) Who / what are they accountable to, or regulated by?**	**(2) Who/ what are they influenced by?**	**Secondary advocacy targets**
Government minsters	Benefit: takes you straight to the source of power. Drawbacks: they are largely supportive of criminalisation of drug use and may not be prepared to listen to our campaign message.	Political leadership Voters	Voters / public opinion Media Political opposition	Voters/general public Political opposition
Public prosecutors	Benefit: You can address issues such as standards of evidence and discriminatory use of the law directly with key decision makers. Drawback: You will not be able to secure repeal of the law.	Their own prosecutorial guidelines National legislature National/ regional human rights frameworks Constitutional court International human rights law	Government Media	Media Sympathetic politicians within national legislatures
Media outlets	Benefit: provide a powerful lever for influence on public opinion and political and other actors. Drawback: have the potential to provoke a backlash against the campaign.	National laws/ regulatory frameworks National legislature	Public opinion	Sympathetic politicians within national legislatures

Adapted from Amnesty International Body Politics Campaigning Toolkit

Information to be covered in this session (Slides 81-83)

It is important to identify the people or institutions who have the power to make the change that you want to see. There are probably many decision-makers who have some influence over your issue. You need to pinpoint who has the most power to make the changes you want. These will be your primary advocacy targets and you will spend most of your time trying to access and influence them. You will need to regularly update your mapping of advocacy targets as they could change as the political context of your country changes e.g. after an election or cabinet shuffle.

Not all advocacy targets may be immediately responsive to us or our work. In some instances, it may be counterproductive to engage directly with the primary target too early in a campaign as it could lead to those in power dismissing or rejecting our issue without any consideration or debate, or provoke a backlash.

You should be aiming to build enough momentum behind your advocacy campaign to ensure that your main advocacy targets are motivated to engage with you. To do this, you have to consider the individuals or organisations that you want to reach; how they interact with your allies and opponents; and which individuals or organisations can help you influence your main campaigning targets. This will help you to identify where the opportunities for influence lie.

Example: Primary and secondary advocacy targets

- If you are working on a campaign to decriminalise drug use, depending on the country context, the Minister of Justice is likely to be your primary advocacy target. As the person responsible for making and changing laws, you will have to persuade the Minister to change the laws. Ministers usually have advisors who research and write papers to help them make decisions, so it is important not to forget about them. In many cases, it is more important at the beginning of a campaign to engage with the advisers so that you can find out what the Minister thinks about drug use. This will help you develop a more targeted approach.
- The Minister of Health may be a secondary advocacy target – while not the main decision-maker on the regulation of drugs, he or she may be able to influence the primary advocacy target because he or she has an interest in changing laws that undermine national HIV prevention and treatment programmes for key populations.
- The national Human Rights Commission or Law Commission may also be secondary advocacy targets – they are trying to ensure that national laws uphold human rights standards; the criminalisation of drug use may be a potential law for investigation and review since it violates the human rights of people who use drugs and undermines universal access to HIV and broader health services. The Commission may be able to influence the Minister of Justice by arguing that the current laws are not consistent with human rights and should be reviewed.

Session 6.8

Activity: Step 5: Identifying existing spaces/arenas where decision-making takes place

FACILITATORS NOTE

Duration: 20 minutes

Slides to be presented: Slides 79-80

Aim: To identify existing spaces/arenas where decision-making takes place

Steps:

1. Introduce the aim of the session
2. Present the guidance on identifying existing spaces or arenas where decision-making takes place on slides 79-80
3. Ask participants to spend 10 minutes brainstorming spaces or arenas or processes where decision making relevant to their advocacy goal is or will be taking place where they need to ensure the representation of people who use drugs and to write these up on a flip chart.
4. Ask participants to use the following questions to guide their brainstorming:
   - Where is the space/arena?
   - What kind of change can we influence through this space?
   - Who manages the space?
   - How accessible is the space? Can civil society participate? What is the level of participation?
   - What do we need to be able to meaningfully participate in that space? (including contact person, resources, data to back up our advocacy asks, etc.
   - Who should be representing? How do we ensure our representation is accountable to the voices of the community?

Information to be covered in this session (Slides 79-80)

If your advocacy goal is decriminalisation of drug use, then it is likely that your focus will be on our national parliament where the necessary decision making to change laws ultimately takes place. However, where the decision making takes place that is relevant to our advocacy will depend on your advocacy goal. There are many other key processes and spaces that influence decision making relevant to your advocacy. If, for example, your advocacy goal is the inclusion of the 10:10:10 targets in the new national HIV strategic plan in your country, then you need to ensure that you engage in the national consultative process that influences the content of the new plan. Similarly, if your advocacy goal is to ensure adequate funding for the expansion of harm reduction services in your country or region, you will need to make sure to engage, for example, in the annual PEPFAR Country Operational Plan (COP) / Regional Operational

Plan (ROP) process. Every year, PEPFAR engages in a planning process to create a Country/Regional Operational Plan (COP/ROP) for each major country or region that receives funding. The resulting plan sets out the budget, targets, geographic focus, and expected impact of PEPFAR funding for the following fiscal year. Implementation follows the U.S. fiscal year—so it begins in October of each year and ends in September of the next year. You can read more about how to effectively engage in the COP/ROP process here.

Another space in which you should be seeking to gain representation for people who use drugs is the Global Fund Country Co-ordinating Mechanism (CCM), which is responsible for coordinating the development and submission of country funding requests to the Global Fund and for overseeing the implementation of the approved programs. People who use drugs are currently completely under-represented on CCMs. If representation on the CCM is not immediately achievable, it is also important for you to make sure that you engage in country consultations that are held in the course of the development of Global Fund country funding proposals to ensure that the needs of people who use drugs are addressed in the proposal. Additionally, it is important to understand the different Global Fund related processes beyond country funding request, as a lot of these spaces are important opportunity to influence changes. These may include the technical working group where Primary Recipients, including partners such as the UN organisations provide regular updates and their performance report. As these spaces often include key people in the HIV response, including the Ministry of Health, it is good opportunity to raise issues related to criminalisation of drug use, lack of access to harm reduction services and their availability. In some countries, successful advocacy through these spaces may lead to reprogramming and redirecting some of the funding to address the barriers and/or to purchase emergency stock of needles and syringes.

Session 6.9

Activity: Step 6: Identifying key stakeholders: partners, allies and opponents

FACILITATORS NOTE:

Duration: 1 hour 15 minutes

Slides to be presented: Slides 81-83

Aim: To identify individuals, groups or institutions that can help in achieving our advocacy objectives

Steps:

1. Introduce the aim of the session
2. Provide each group with a copy of Handout 7
3. Present the guidance on identifying key stakeholders: partners, allies and opponents on slides 81-83

4. Working with the whole group, clarify the difference between a target and an ally, and how some allies can also be indirect targets.
5. Facilitate a discussion with participants to share their experiences of working in non-advocacy-related partnerships or coalitions for their work.
6. Focus the discussion on working in partnerships specifically for advocacy. Questions might include:
   - What are your experiences of advocacy work with others?
   - What were the main advantages and disadvantages you identified in working with others to undertake advocacy?
   - What are the differences and similarities between partnerships for advocacy and partnerships for other activities?
7. Ask participants to use the table below to identify their potential allies. Give them the following guideline questions:
   - Who else could have a positive impact on the issue that has been chosen? Who else is already working on this issue?
   - Who are usually your "natural" allies? Are they relevant allies for this issue?
   - Are they happy to work in a coalition?
   - If it is not currently possible to work in a coalition, what do we need to do to make it possible to work in a coalition in the future?
8. Ask the participants to consider, for each ally:
   - What they will gain by joining your alliance
   - What they can offer to the advocacy work
   - What their limitations are.

Type of power	Rationale	Example
Members: are they a large organisation with many members?	A group with many members is less likely to be ignored by decision-makers, the media and the public	Trade unions can mobilise their members to attend demonstrations
Money: will they donate money to your organisation or cause or do they have strong connections with donors?	Access to donor funding gives organisations the resources they need to do advocacy	Large international NGOs can introduce you to donors overseas that you would not otherwise have access to
Credibility	A group or individual who is respected by decision-makers and/or the media can lend that credibility to your cause	A well- known and well-liked activist can speak out about drug use without fear of stigma and discrimination
Appeal: do they have a special appeal for the media?	Public personalities can have universal appeal and connecting with them can help advance the rights of people who use drugs	A celebrity or national sports person can be an important spokesperson for drug policy issues if they are briefed by you
Network: are they part of an organised network?	Working with a group that is part of a larger network can give to access to other organisations that are part of the network, their resources and credibility	An international network can amplify your advocacy efforts in international settings
Reputation: are they well known as a group which does high quality work and who will not back down?	Working with a group that is recognised as an expert can enhance your credibility	An ally that has already successfully made change will be seen by the media and decision-makers as an effective voice on your issues
Skills: do they have skills that your organisation does not have?	An ally can bring technical, media, legal and other skills that will advance your advocacy	A coalition that includes lawyers can make credible arguments on law reform
Newsworthy: is the organisation newsworthy or does it have strong relationships with the media?	Some groups will already have strong relationships with the media that you can build on	A group that is already doing advocacy on high profile issues

Adapted from Carroll A (2010) Make it Work: Six steps to effective LGBT human rights advocacy, ILGA.

Information to be covered in this session (Slides81-83)

Understanding who will help and support you to achieve your goal is very important, but it is equally important to know who might try to oppose our efforts. Once you have analysed the issues, you should also map who your allies and potential advocacy partners are, identify your advocacy targets (the people and institutions that have the power to make the change that you want) and who will oppose your advocacy goals. A careful and thorough mapping process is critical to understanding how you will engage with each set of stakeholders to advance your advocacy.

Example: Who are the key stakeholders?

- Opponents: organisations or individuals who oppose your position, but who are not in decision making positions e.g. religious institutions or non-governmental organisations (NGOs) that do not support people who use drugs having human rights, or do not understand the links between HIV and human rights. They are important because they may have influence with decision-makers and they could actively work against your goal.
- Beneficiaries: the people whose issue you are representing – people who use drugs, their sexual partners, families of people who use drugs
- Allies: organisations that support your position and who may be able to help you achieve your advocacy goal. These can be local or international organisations
- Decision-makers: these are your advocacy targets and they are the individuals within government that make or influence decisions.

Adapted from Carroll A (2010) Make it Work: Six steps to effective LGBT human rights advocacy, ILGA.

It is really important to find out as much information as possible about each group of stakeholders and what their position is on the issue that you are working on. Successful advocacy often depends on having good relationships with all stakeholders, even your opponents. Nurturing relationships with key individuals takes time.

Allies and partners

Working in partnership with others or as a part of a coalition can amplify your advocacy message and help to build legitimacy and credibility with your advocacy targets. Sometimes, the more people fighting for a goal, the more decision-makers are likely to pay attention. You will need to invest time understanding, exploring, educating and informing each other about the links between human rights and HIV. These relationships also take time and energy to maintain – everyone needs to be up to date on what is happening and should share information and strategies.

Coalitions can be short term or long term, and formal or informal. For example, in the short term they can take advantage of gatherings such as meetings, conferences and workshops to

promote an issue and gather signatures for petitions. Alternatively, campaigns and actions can be undertaken over several years. Forming a coalition with allies to undertake advocacy work is not the same as being part of a network, but networks can also be useful to share information between organisations.

Examples of possible allies to form coalitions include:

- Other people directly affected by the issue or problem, such as people who use drugs, or small-scale subsistence farmers engaged in the production of drug linked crops
- Other drug user service organisations, CSOs, NGOs, including human rights and health organisations
- UNAIDS
- Religious leaders and other community opinion formers
- Businesspeople
- Local celebrities or public figures
- Known allies from within the law enforcement sector
- Supportive or sympathetic journalists
- Supportive local/national government officials who can lobby from inside
- Allies in other parts of the country, or other countries – counterpart organisations who could push from outside.

Considerations when forming a coalition:

In some settings, civic space is very limited and restricted. Certain issues that are considered very sensitive may be seen as a red flag by the government. This situation may affect the way the coalition works, particularly in terms of visibility of organisations as members of the coalition. For instance, in countries where people who use drugs are extrajudicially killed, drug user-led networks and organisations shall not be too visible due to security and safety issues. Some UN organisations may not be seen taking part in any activities related to protecting human rights. When developing a coalition, be clear about our advocacy plan, map out the different roles each member can take, acknowledge the limitations, and develop emergency response mechanism.

In some settings, it may not be possible to create a coalition, especially where there is a lack of trust towards drug user-led network, including in countries where the network is newly formed. It is important that we continue our work. We may want to seek support from 'neutral' organisations such as the UNs to develop our capacity and to facilitate discussions and dialogues with other organisations working on same issues. International organisations may also be able to support as they often have existing partnership with several local organisations. Regardless of the reasons, this cannot stop us for fighting for our own rights.

Opponents

Groups working advocacy can face resistance and opposition. This opposition may come from many different sources, including from your primary advocacy targets, other NGOs, the media, religious institutions and members of the public.

It is important to map who they are and to assess whether and which ones are the most important to engage with - either to neutralise their opposition, undermine their arguments, or even turn them into allies. Who these are will vary from case to case.

Since our ultimate target is a law reform that fully decriminalise drug use, it is also important for us to understand how the systems work in our country. We may have potential allies in the Parliament, but if the majority of seats are taken by people from conservative parties, we may want to strategise on developing seeds to grow more supportive generation of future politician leaders. At this level, people often have to put aside their personal opinion, even if they support full decriminalisation, they may not be able to fight for that because their opinion may not be their party's position on drugs. It is important that we learn from other civil society movements on their successes in turning the favour against them on issues that are as sensitive as drugs.

Session 6.10

Activity: Step 7: Identifying the types of advocacy methods

FACILITATORS NOTE:

Duration: 2 hours 

Slides to be presented: Slides 84-100 

Aim: To identify the types of advocacy methods that will work best to achieve your advocacy goals

Steps:

1. Introduce the aim of the session
2. Present the guidance identifying the types of advocacy methods that will work best to achieve your advocacy goals on slides 84-100
3. Facilitate a discussion with participants in plenary to share their experiences of using different types of advocacy methods.
4. Split participants into three groups for 30 minutes.
5. Explain the task: to develop a short case study of human rights violations based on a real event they are aware of or have experienced themselves and to write a press release on the case study that they develop.
6. Have participants write up the case study up on a flipchart.
7. Ask the participants to write up their press release on a separate flip chart.

8. Have each group report back to the plenary and assess their case study and press release against the 6W Guide.
9. Stimulate a discussion around this (8 minutes for presentation, critique and discussion per case study). Emphasise that answering each of the 6W questions (what, where, when, who, why, how) is essential to effectively record and document incidences of human rights violations as well as for an effective press release.
10. Using the 6W Guide, go through each case study from the group work, and check that all the 6W questions have been addressed. Facilitate discussion with participants and encourage them to identify what is missing.

Information to be covered in this session (Slides 84-100)

There are various things you can do to achieve your advocacy goals. Your advocacy strategy can include one or a combination of these approaches that will best address the issue, such as:

- Lobbying decision-makers
- Using the media
- Mass Action
- Documentation
- Litigation.

Key questions to ask when deciding what advocacy method will work best for you:

- The political, social and cultural context within which you are working, and the opportunities and constraints presented by that context
- The timing and the different upcoming opportunities (or constraints) presented by that particular time, such as the review of or drafting of a new national HIV strategic plan or the review of national drug policy, elections or international conferences
- Your organisation and its own strengths, weaknesses and skills, as well as that of partners – your advocacy tools should build on the strengths of your and your partners' organisations
- The risks involved in the various approaches.

Lobbying decisions makers

One of the most important ways to bring about change is to lobby decision-makers. This strategy is often used with other strategies to advocate for a change in a law, policy or programme. Talking directly to your advocacy targets can be the most direct way to bring about change as it allows you to tell the people who have the power to make the change that you want.

It can be difficult to get a meeting with a high-level decision maker and it can be helpful if you already have a relationship with their advisors, who might persuade them to meet you. It can be useful to bring survivors of war on drugs human rights violations to advocacy meetings as this may be the first opportunity your advocacy targets have to hear firsthand how survivors are affected by specific laws, policies and programmes. This can be a powerful way of showing policy makers why change is necessary.

Tips for meeting with decision- makers

1. Developing the content of your presentation:
    - Focus on your key message and whatever background information your audience needs.
2. What is your key message or ask?
    - Pick no more than three priorities or asks, plus back-ups.
3. What is the reason for your ask?
    - Sum this up in a few sentences –for yourself and for others.
    - Discuss facts/data and stories/ anecdotes about the impact of the law or policy that you are seeking to change on the lives of people who use drugs. Refer back to the information provided in Unit 3.
4. What are you asking the policy or decision maker?
    - Make sure you know what exactly you want them to do.

For more information on meeting with policy makers refer to the INPUD Injecting Drug User Implementation Tool Training Manual at page 55 here.

Using the media

Media campaigns use the print, electronic and broadcasting media to raise awareness, about HIV related abuses, destigmatise people who use drugs, people living with HIV, HCV and/or TB and key groups and increase support for, as well as the visibility of people who use drugs, people living with HIV, HCV and/or TB and HIV, HCV, TB and human rights issues amongst the public. Media campaigns are also an important complementary strategy to other advocacy tools, such as litigation or mass action, in order to increase awareness, understanding and support for the goals of the broader campaign and to increase pressure on your advocacy target.

Media campaigns may include using newspapers (either writing your own opinion pieces or supporting sensitised journalists) to produce news articles, opinion pieces, editorials and press releases, using broadcast media to hold radio or television discussions and dialogues or to integrate HIV, drug use , harm reduction and human rights issues and messages into popular local radio or TV shows, as well as producing other forms of media such as newsletters, pamphlets, leaflets, posters, artwork and banners to accompany advocacy campaigns.

Case Study: Using meetings with policy makers and the media

In order to draw a discussion on the Supervised Injection Facilities issue in France, a group of associations opened one in Paris on the World Hepatitis Day on May 19th, 2009. The SIF was equipped with sterile drug consumption material, supervised by health professionals... though drug users were not allowed to use the premises due to French drug regulation. Many journalists, attracted by what they believed to be an illegal action (we did not mention in our press release that drug would not be allowed) came to visit the SIF. They were able to discuss with health professionals and expressed a general positive opinion toward the topic in their reports.

This media success allowed us to start a political lobbying action aimed to advocate the experiment of a SIF in Paris. Numerous appointments with political leaders led to two important decisions. Health Minister Roselyne Bachelot announced that such an experiment would be allowed depending on the notice of a national scientific expert committee (INSERM) and the city council of Paris sponsored a seminar on SIFs aimed for elected representatives of several French cities.

Source: https://idpc.net/media/press-releases/2010/05/mock-supervised-sif-as-step-forward-for-harm-reduction

Writing a press release

If you have newsworthy information you want to communicate to journalists so that they write about it, sending them a press release is a good way to let them know the details. You should only send out press releases if there is something new about the issue. A press release is not a good way to communicate information that journalists already know about or to provide detailed information about complex issues.

It is important that you send the press release to as many news outlets as possible. If you plan to send out press releases regularly, it is worth spending time creating a list of journalists, along with their contact details. This list will need to be updated from time to time.

Tips: Drafting a press release

- Put the most important part of your story at the beginning of the press release. Your first sentence should try to cover the 6 Ws – who, what, why, where, when and how
- Be concise – your press release should aim to be between 300 – 400 words. If it is too long, journalists will probably not read all of it
- Include quotes. if you can include a concise and insightful quote, some journalists will publish it word for word
- Include contact details – if journalists want more information, they must be able to contact you, so include your phone number and email address

Mass action

Mass action is an activity taken on by a large group of people to persuade decision-makers to change.

Demonstrations and marches are a form of mass action. Sanctions (refusing to buy products from a certain organisation or country) can also be a kind of mass action. Petitions and letter writing campaigns from members of the public directed towards your advocacy target can also be a form of mass action. Mass action, while it can help raise awareness and increase knowledge about drug policy issues and mobilise communities, uses the power of many people to bring public attention to an issue to compel decision makers to bring about change. In 2017 in North Richmond, Australia mass action in the form of public demonstrations on the streets, joined by hundreds of people from all walks of life calling for the establishment of a supervised injecting facility to address the high levels of overdose fatalities being recorded in the area.

Case Study

Challenging police raids and criminalisation of drug use in Hungary through "civil obedience"

The Problem

In Hungary, police regularly raided discos and forced young club-goers to undergo urine tests. This violated privacy rights and rules of criminal procedure, and potentially forced discos underground, making it more difficult to conduct harm reduction outreach with club-goers.

Actions Taken

The Hempseed Association and the Hungarian Civil Liberties Union challenged the police practice of raiding discos and conducting forced urine tests in order to catch people using drugs. Led by the Hempseed Association and with legal advice and representation from the HCLU, individuals reported to the National Police Headquarters in Budapest in the spring of 2005 to confess their non-violent drug use. The aim of this "Civil Obedience Movement" was to challenge the practice of forced urine tests and to raise the issue of decriminalisation of drug use.

Every Wednesday for five weeks, "self-reporters" including celebrities appeared at police headquarters. The HCLU provided each self-reporter with a legal manual. More than 60 people self-reported in total.

The action attracted significant media attention and dominated public debate for weeks. Activists expressed their views to the media about the illegal practice of police raids and about decriminalisation.

HCLU made freedom-of-information requests to the police about the cost of police raids, and used the data to show the raids were not cost-effective.

Results and Lessons Learned

The action succeeded in its main goal, which was to obtain a statement from the police that urine tests could only be conducted on someone following initiation of a criminal procedure against them. This effectively made urine test raids unlawful. The number of police raids seriously decreased, with very few raids occurring in 2006.

The campaign also succeeded in making decriminalisation of drug use a subject of mainstream debate. More than 70 professionals working on the drug field signed a petition supporting the aims of the campaign. Three months after the action, the first-ever draft bill on decriminalisation was introduced in parliament.

The campaign showed that good stories and human faces are an important and successful way of achieving media coverage of drug policy campaigns.

Source FXB Centre for Health and Human Rights at Harvard University, Health and Human Rights Resource Guide https://www.hhrguide.org/2014/03/12/example-3-challenging-police-raids-and-criminalization-of-drug-use-in-hungary-through-civil-obedience/

Documentation

Documentation (or fact finding) of human rights abuses is collecting information about human rights violations from survivors of those abuses that can be used to educate policy makers and the public about human rights violations against people who use drugs, litigate against abusers and create a public record of the abuse. Documentation can also be useful in allowing you to do evidence-based advocacy.

You will need to carefully design your documentation project, making sure that you understand what information you need to collect to advance your advocacy objectives. It will be important to know how you are going to use the information as this will also determine what type of information you collect, how much evidence you will need to gather and what resources are necessary. For example, if you plan to produce a report, you will need to interview a sufficiently large number of people to give your claims credibility. If you plan to include direct testimony from those whose rights are violated in a letter to the government, you may not need to interview a large number of people.

Working through the following checklist below may help you to design your investigation.

- What are the issues we will be investigating? What is the nature of the discrimination, violence, and abuse against people who use drugs, how does it link to their vulnerability to HIV and their ability to access HIV and other health services? What are the consequences of the abuse?

- For what reason are we documenting abuses?
- What strategies will we use to investigate?
- What support and resources will we need?
- What are the risks or benefits of doing such an investigation?
- What methods could we use to draw attention to our findings?
- What do we wish to achieve as a result of the investigation?
- What recourse do we have against the abusers?
- What international and regional human rights treaties has the government ratified?
- What is the local human rights framework?[58]

The 6 Ws

What What violation occurred? What was the accusation made, the law cited or the weapon used?

Where The street, building or facility, and the address

When The time, day, date and year of the incident

Who Who was the direct victim? Who were the perpetrators? Are there witnesses or other people with direct knowledge of the violation (e.g. medical staff, police, outreach workers)?

Why Gather assessments or documentation from those most closely involved as to the circumstances, motivations, actions or words that led up to the violation.

How How did the violation occur, and how did the victim's status as a person who uses drugs contribute to the violation?

When you have completed your interviews and gathered all evidence that you need, you will need to analyse it and eventually publicise it.

There are also some existing reporting mechanisms for human rights violations such as Rights – Evidence – ACTion (REAct), which has been built with communities in mind, so that community-based organisations (CBOs) can monitor human rights issues and respond to them. Organisations can use REAct to record data about human rights violations; provide and refer people to health, legal and other public services; and use this data to inform human rights-based HIV programming, policy and advocacy at national, regional and global levels. For further information on REAct see https://frontlineaids.org/resources/react-user-guide/

58. Adapted from: Open Society Institute (2009) Human Rights Documentation and Advocacy: A Guide for Organisations of People Who Use Drugs, 2009, available at : http://www.opensocietyfoundations.org/sites/default/files/hrdoc_20090218.pdf

Case Study

Ukraine: The Importance of Documentation

Kostyantin Zverkov from the organisation Era Miloserdiya in Odessa, Ukraine, described how important thorough documentation has been to his organisation's advocacy on behalf of drug users. "We use our reports when we do advocacy with government officials, such as public health officials. We'll have meetings with people in positions of leadership at medical institutions or in the government. We bring our reports [documenting human rights violations against drug users] to these meetings. When the officials see that we have documented everything, that we have written it all down accurately and clearly, they are forced to admit that these problems exist. They already can't escape it. They can't deny that there are problems the way that they usually try to do when there isn't such evidence presented to them. And, with that, they are forced to change the situation and guarantee that there are better practices and better treatment of drug users."

For example, in response to reports from drug users seeking treatment for tuberculosis that they had been ill-treated by medical staff or denied services and treatment, Era Miloserdiya launched a documentation project. Project staff sought to stop these abuses and change the attitudes and behaviour of medical personnel by documenting rights violations through interviews with around 100 drug users on the basis of a carefully developed questionnaire. On the basis of the research, they provided concrete recommendations to the leadership of the relevant medical institutions regarding necessary changes in how treatment is provided.

Source: Open Society Institute, Human Rights Documentation And Advocacy A Guide For Organizations Of People Who Use Drugs, 2009

Litigation

Litigation (bringing an action to court) is another useful strategy to bring about change to laws and policies. Challenges to law or policy can take place:

- using national bodies (like courts and commissions), or
- using regional and international bodies (like the African Commission or European Court of Human Rights)

It will be important to choose the case that you bring to court carefully – one of the main reasons for

Litigating cases is to set a precedent for future cases, so it is important to avoid cases that could set bad precedents. Before starting litigation, you should evaluate the consequences of losing the case – this may mean that a bad precedent will be set that will undermine future cases and reinforce existing laws that are harmful. This is not always the case and sometimes you may still decide to go to court even when you do not have a reasonable chance of success

because the case will still be an important opportunity to raise awareness about human rights violations against people who use drugs.[59] The safety and security of people who use drugs must also be seriously considered, as well as the mental and emotional burden of going through a lengthy and intrusive court case.

Example: Key questions to consider before litigation

- What is the risk of a bad judgment and bad precedent?
- What are the facts of the case?
- What is in the interest of clients?
- Are the courts sufficiently independent to be willing to engage on issues?
- Has the court indicated sympathy for drug policy cases before?
- Do the courts understand the links between drug policy and human rights? What are their misconceptions and prejudices?
- Have we done enough groundwork to ensure judges and public are sympathetic to the issues?

Case Study

Litigation to prevent closure of a supervised injection facility in Canada

A Vancouver-based non-government organisation two local people who inject drugs took the federal government to the Supreme Court of British Columbia in an effort to prevent the closure of *Insite*, a supervised injection facility. The Supreme Court judge ruled in support of the continued operation of *Insite*, recognised it as a health service, and noted that it would be unconstitutional to deny people who inject drugs access to this life saving service. The federal government appealed, and the appeal court judges also ruled in favour of the continued operation of *Insite*. Again, the federal government appealed to the Supreme Court of Canada. The non-governmental organisation and local people who inject drugs leading the case were supported by a range of intervenors, including the Canadian Medical Association, the Canadian Association of Nurses, and the Canadian Public Health Association. The Supreme Court justices ruled 9–0 in favour of the continued operation of *Insite* and in their decision stated:

"The Minister's failure to grant [an exemption] to *Insite*...contravened the principles of fundamental justice...*Insite* has been proven to save lives with no discernible negative impact on the public safety and health objectives of Canada...(p. 139)"

Supreme Court of Canada. Canada (Attorney General) v. PHS Community Services Society. In: Canada SCo, editor. [2011] 3 SCR 134, vol. 33556. Ottawa: Canada SCo; 2011.

59. Carroll A (2010) Make It Work: Six steps to effective LGBT human rights advocacy, ILGA at p95

Session 6.11

Activity: Step 7: Identifying resources that you will need for your advocacy

FACILITATORS NOTE

Duration: 30 minutes

Slides to be presented: Slides 101

Aim: To identify the resources that you will need for your advocacy

Steps:

1. Introduce the aim of the session
2. Present the guidance on identifying the resources needed on slides 101
3. Ask the whole group to brainstorm what kinds of resources are useful for advocacy work. You could give the following examples if necessary:
   - People
   - Contacts
   - Information
   - Skills
   - Money
   - Equipment.
4. Ask the three groups to identify all the resources available to address the advocacy objective as well as the additional resources that will be required and to note this down on a flipchart.

Information to be covered in this session (Slides 101)

Successful advocacy work requires resources such as people (human resources), money, skills and information. Human resources can include both staff and volunteers. Other resources can include access to the media and distribution networks – for example, newsletters, e-mail lists, etc. One of the benefits of working in coalition with allies is the possibility of sharing resources.

Once you have identified available resources, you can go on to developing an action plan. It is best to plan only for activities that are possible with the resources you have. However, it is sometimes possible to fundraise for advocacy work – although this can be very difficult in some countries and for some issues.

Session 6.12

Activity: Step 8: Creating an advocacy action plan

FACILITATORS NOTE

Duration: 3 hours

Slides to be presented: slides 102-103

Aim: To develop an action plan / roadmap for your advocacy

Steps:

1. Introduce the aim of the session and explain that this is the session where participants will use all the work that they have done thus far to develop an advocacy action plan / roadmap. Refer them back to the work that they did in the previous sessions to identify:
   - The issue or problem that they have chosen to address through advocacy
   - Their advocacy goal or aim and objectives
   - Their partners, allies and opponents
   - Available resources for advocacy
2. Make sure that all three groups have Handout 3
3. Explain that the session will be in two parts.
   - selecting appropriate advocacy activities, and
   - making a detailed plan for those activities.
4. Present the guidance on developing an advocacy action plan on slides 102-103

PART A: Selecting advocacy activities

- Ask the groups to decide which advocacy methods they want to use.
  They should look at:
  - ✔ the advocacy targets they have identified
  - ✔ the information they gathered or identified when researching the issue
  - ✔ the list of advocacy methods considered in the previous session
  - ✔ the resources available.
- Give them these guideline questions:
  - ✔ Why does each target support or oppose the advocacy solution?
  - ✔ How can each target be moved towards supporting the advocacy solution?

PART B: Drafting an advocacy action plan

- After they have decided on the advocacy methods (activities) to use, the groups should use the table suggested below to draft their advocacy action plan.
- Ask participants to practise developing an action plan, so that they are familiar with

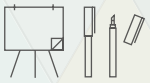
the process. They can plan the activities that they have agreed on. Ask the groups to present their action plans to the others and encourage them to discuss the plans and ask any questions that they may have.

- After they have practised action planning, go straight to a discussion with the whole group, without presentations:
  - ✔ What factors did you consider in planning advocacy work?
  - ✔ What factors might require you to change your action?

Objective	Objective 1 - By July 2023, three influential members of parliament will make positive public statements supporting the decriminalisation of people who use drugs
Target	Influential parliamentarians and their senior advisors Members of the Public
Activities	Meetings with three parliamentarians
Resources required	Team leader Team to organise events and logistics Volunteers Access to the media Funding Venue for the Meetings
Persons /organisations responsible	Team leader
Timeframe	By May 2023
Expected Outcome	Positive support from 3 parliamentarians in public statements.

Note to facilitator: If time permits and participants have the information available to cost the plan, ask participants to add a column to the table with the estimated costs of each activity.

Materials:

- Flipchart and marker pens 
- Handout 3 

Information to be covered in this session (Slides 102-103)

The work done in the previous activities will help to choose appropriate advocacy activities to achieve your aim. By now, you know what you are trying to achieve, who your targets are, who your allies are, and resources available. We have also looked at the different methods of advocacy, which will help you in selecting activities. When identifying activities it is important to consider who will be the beneficiary of the actions and involve them, if possible. For example, impact will be greater if a group of people who use drugs is supported to meet directly with a senior police officer, rather than an NGO representative attending the meeting on their behalf. However, this will largely depend on the local context, including the levels of stigma associated with drug use, and the potential risks of arrest or police abuse.

Identifying advocacy methods

There are no simple rules for choosing the best advocacy methods. Your choice will depend on many factors:

- ✔ the target person/group/institution
- ✔ the advocacy issue
- ✔ your advocacy objective
- ✔ the evidence to support your objective
- ✔ the skills and resources of your coalition
- ✔ timing – e.g. external political events, when a law is still in draft form, immediately before a budgeting process, time of year, stage of advocacy process.

Developing and delivering a message efficiently

The message should use language that the target group will understand. It should be clear and simple, avoid technical terms, and use positive images rather than negative connotations.

The messenger is often as important as the message itself. Therefore, if the message is being disseminated via the press, it will be important to use a newspaper that is widely read and respected. If the target group is law enforcement officers, you can use a high-level police chief or retired police officer who will act as your spokesperson. If the message is targeted at a community where religion plays an important role, then a religious or faith-based group could be useful to disseminate the message.

Finally, the message will need to be delivered in a consistent way, through various channels, over a long period of time to be absorbed by the audience. Consistency is crucial, but the message may need to be delivered in various ways so that it does not become boring to the target audience.

Session 6.13

Activity: Step 9: Developing a monitoring, evaluation and learning framework

FACILITATORS NOTE

Duration: 45 minutes

Slides to be presented: Slides 104-106

Aim: To understand how to develop a monitoring, evaluation and learning framework for your advocacy

Steps:

1. Introduce the aim of the session
2. Present the guidance on developing a monitoring, evaluation and learning framework for your advocacy on slides 104-106

Information to be covered in this session (Slides 104-106)

Throughout your advocacy, it is important to keep a record of what has worked with your advocacy, what has not worked, and why. This helps to better inform your future advocacy plans. Monitoring and evaluation allows you to assess the impact of your work against your advocacy plan, and to reflect on the successes and failures.

Monitoring: The overarching aim of monitoring is to track progress and, if necessary, to change action plans to respond to unanticipated issues that emerge during your advocacy. Activists should engage in monitoring throughout their advocacy. This can be completed through regular meetings to consider whether particular advocacy activities are being carried out according to plan and whether the objectives are being achieved.

Evaluation: Evaluation looks at whether the advocacy objectives have been achieved, how they were achieved and what activists can learn from the process to inform advocacy moving forward. Evaluation should be carried out at significant points throughout the course of the advocacy (i.e. mid-project, end of project).

There are two primary forms of evaluation: implementation and outcome. The purpose of implementation evaluation is to understand how well you undertook the action. The following questions can be asked when evaluating "advocacy implementation":

- ✔ Are you performing the advocacy activities as planned?
- ✔ Are you reaching the intended target population?
- ✔ Are you reaching the intended number of participants?
- ✔ How do the participants perceive these advocacy activities?

The purpose of outcome evaluation is to understand the overall effectiveness of the advocacy activities to achieve the overarching goal of the advocacy. The following questions can be asked when evaluating "advocacy outcomes":

- ✔ Is the knowledge base and understanding of the advocacy targets being changed?
- ✔ Are the attitudes, behaviours, or awareness of the advocacy targets being shifted?
- ✔ Has there been a tangible change in the law, policy or practice at issue in the advocacy?
- ✔ What are the overarching results of the advocacy?

Learning: In addition to undertaking monitoring and evaluation throughout the advocacy, it is useful to hold meetings with your fellow advocates to discuss the successes and challenges that emerged throughout the advocacy. This provides the opportunity for reflection and learning moving forward, as well as potential "next steps" should the advocacy continue on in some other form. Some questions the group may consider include:

- ✔ What went well?
- ✔ How will we celebrate this success and thank those who helped?
- ✔ What contacts and connections did we make?
- ✔ What challenges do we face?
- ✔ What did we learn that we could use in the future?
- ✔ What new resources became available to us because of this advocacy action or event?
- ✔ Who else could benefit from this information (e.g. new group members or leaders, other networks of people who use drugs, other human rights organisations?)

Session 6.14

Activity: The way forward

FACILITATORS NOTE:

Duration: 30 minutes

Aim: To provide an opportunity to discuss next steps

Steps:

1. Introduce the aim of the session
2. Highlight that the aim of this training workshop has been to equip participants with the information that they need to move forward with developing a plan for their advocacy.
3. In plenary facilitate a discussion with participants on the way forward with the development and implementation of their advocacy plans
4. Thank the participants for their participation in the workshop and stress the importance of community-led advocacy for drug policy and law reform.

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 its 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. www.inpud.net

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INPUD would also like to acknowledge people who use drugs around the world who fight back against criminalisation, stigma and discrimination, harassment, abuse and violence every day. We will continue fighting to change existing local, national, regional and international drug laws and formulate an evidence-based drug policy that respects people's human rights and dignity instead of one fuelled on moralism, stereotypes and lies.

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