

The New Funding Model



Principles of the new funding model

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- **Bigger impact:** focus on countries with the highest disease burden and lowest ability to pay, while keeping the portfolio global
- **Predictable funding:** process and financing levels become more predictable, with higher success rate of applications
- **Ambitious vision:** ability to elicit full expressions of demand and reward ambition
- **Flexible timing:** in line with country schedules, context, and priorities
- **More streamlined:** for both implementers and the Global Fund

New vs. old funding model

Rounds-based funding

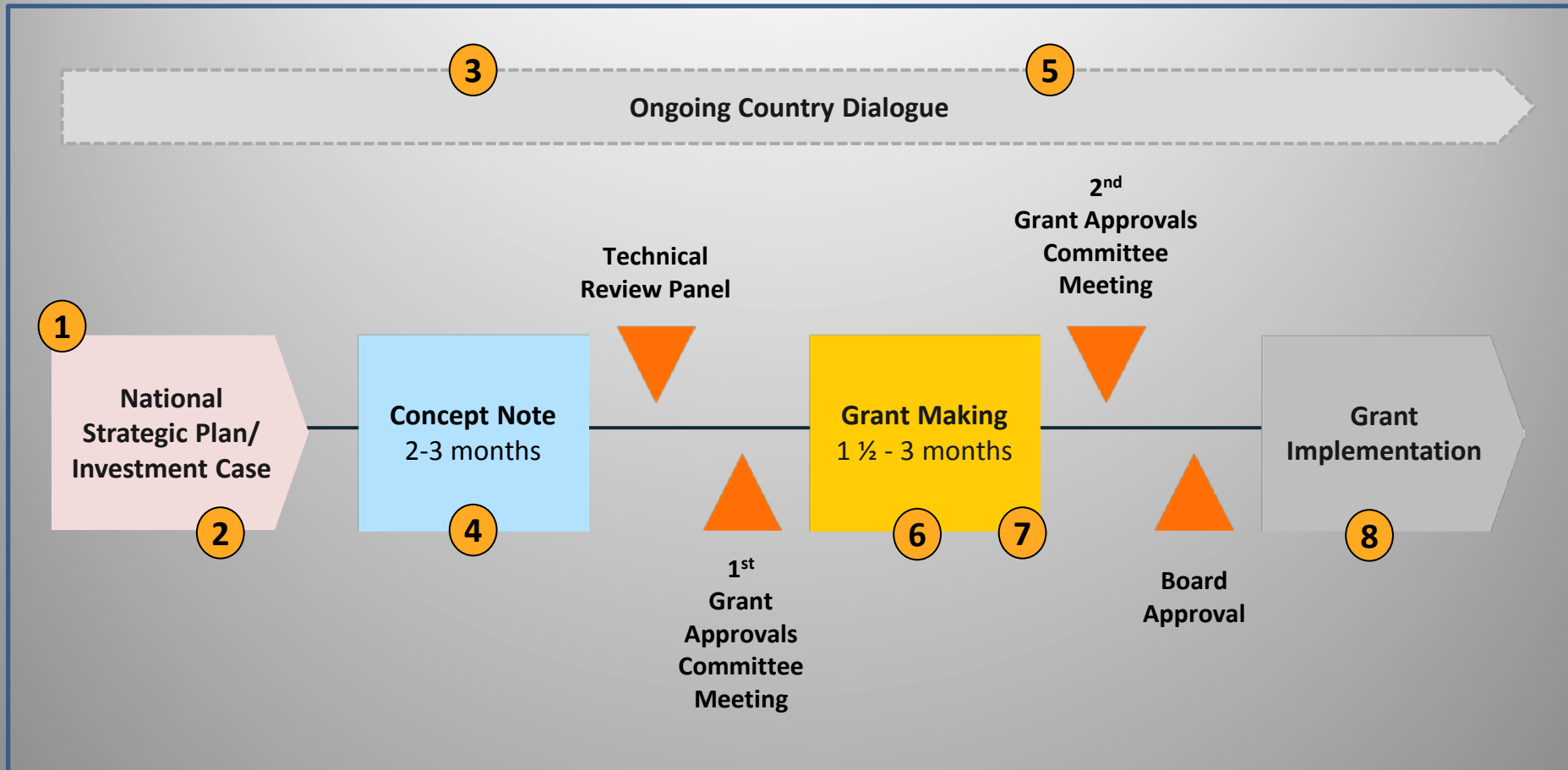
- Investment selection
- Timelines
- Secretariat engagement
- Predictability
- Process



New funding model




- Active portfolio management by Secretariat
- Defined by country
- Involved in country dialogue and concept note development
- Timing, success rates, indicative funding range
- Disbursement-ready grants

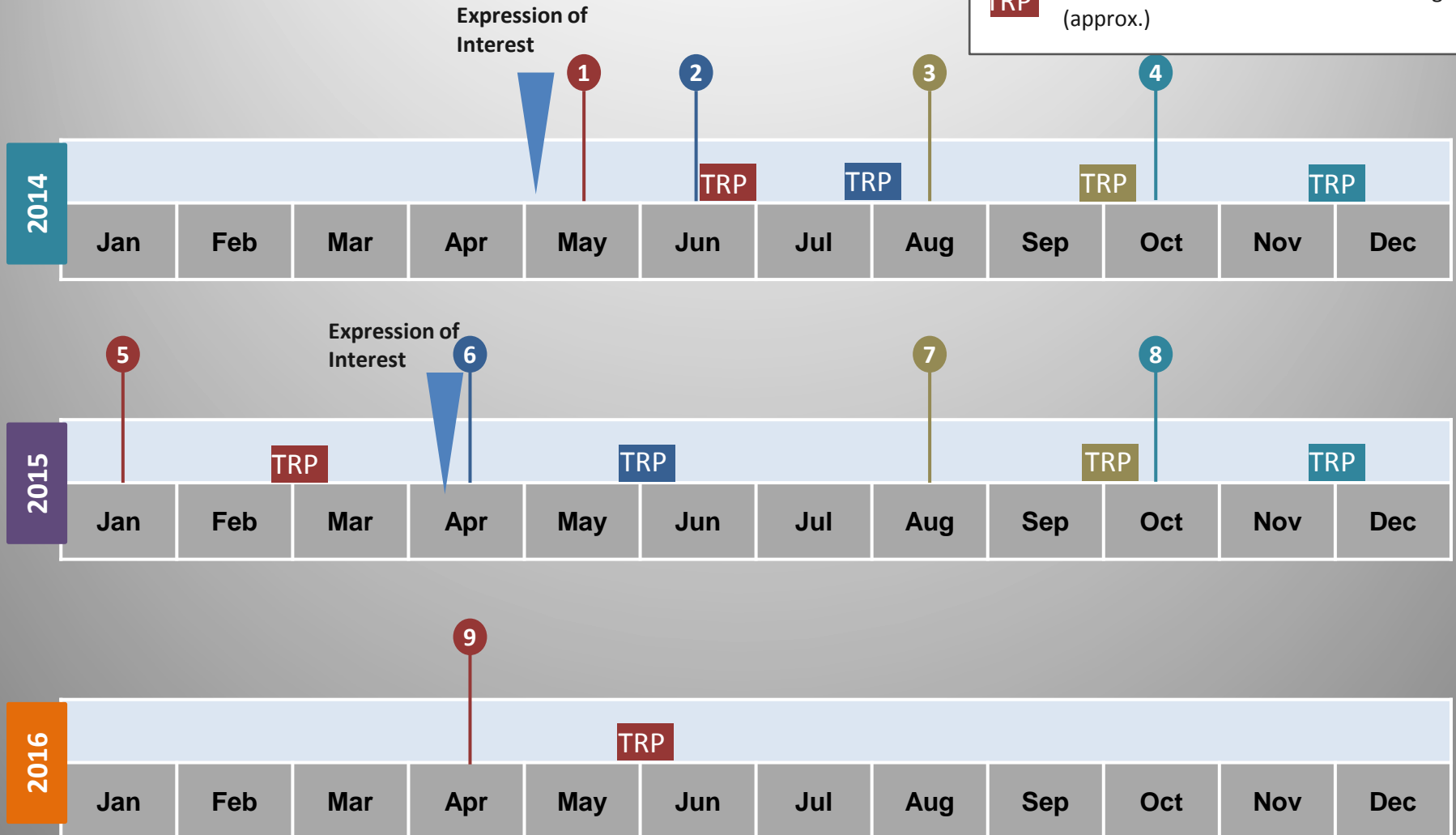
New funding model cycle and timing



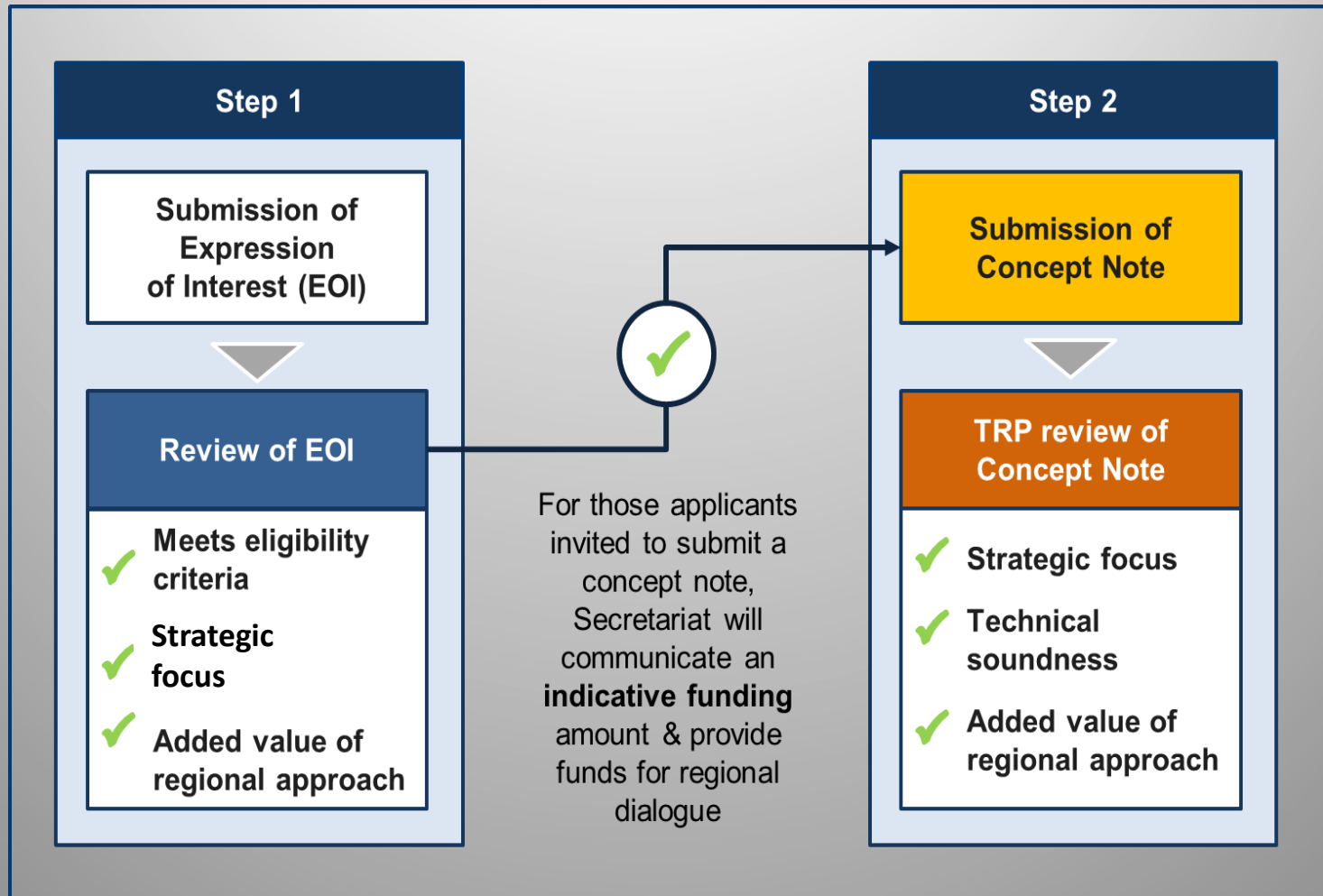
Countries can apply anytime in 2014-2016 – identify now when funds are needed for each disease
Grant funds will run to the next replenishment at least

Submission dates 2014-2016

-  Submission deadline for expression of interest (regional applications only)
-  Submission deadline on 15th of the month
-  Technical Review Panel review meeting (approx.)



Regional applications



Eligibility assessment

Eligibility Requirement 1

Involvement of all stakeholders in concept note review and development

Eligibility Requirement 2

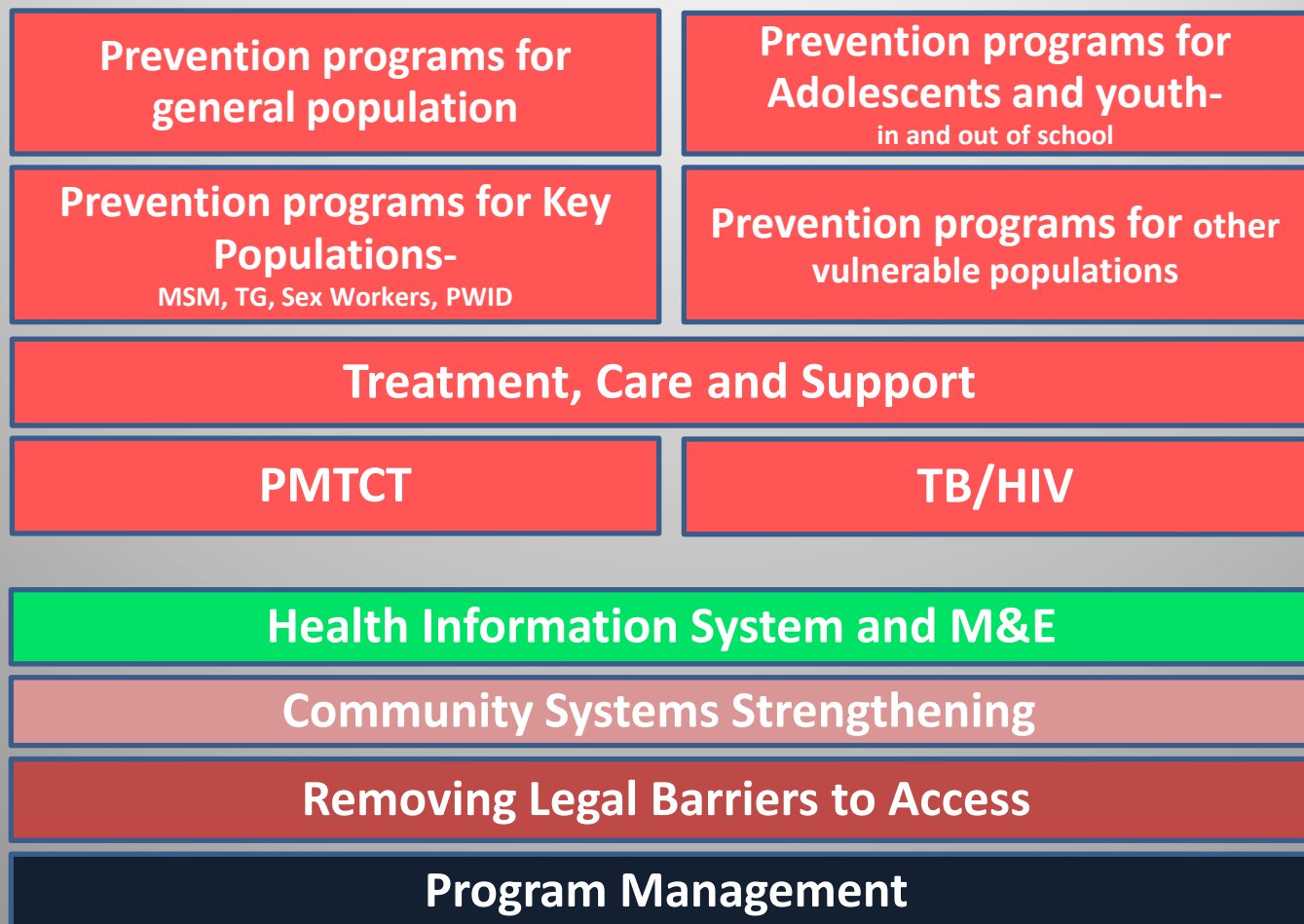
Selection process for Principal Recipients.

Non-compliance with any one of the six requirements could mean an application is NOT eligible and will NOT be reviewed by the Technical Review Panel.

- Documented efforts to involve key population groups and other vulnerable populations.

- Applied equally to new and continuing Principal Recipient(s)
- Based on clearly defined and objective criteria
- Documented management of conflict of interests

Modules under HIV



Global Fund and Harm Reduction



Harm reduction as defined by the Global Fund

An effective and evidence-based response is required to curtail the rapid spread of HIV among drug-injecting populations, but also to prevent onward transmission to other populations (including regular sexual partners and sex workers) which may significantly expand the reach of the epidemic. Harm Reduction refers to policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of drug use – such as HIV transmission – without necessarily reducing drug consumption itself

The Global Fund and Harm Reduction

- Largest international contributor to harm reduction programs in low and upper middle income countries
- At end 2009 – accumulative investment of est 430 million across 55 contexts
- Includes support for Hep C treatment for people with HIV co-infection, access to justice and legal services, community systems strengthening
- Lower-middle and upper-middle income countries applying for funding must focus 50 percent and 100 percent, respectively, on underserved and most-at-risk populations, as well as focus on the highest impact interventions.

Key Components

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counseling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom distribution programs for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

Incorporating harm reduction interventions into Global Fund proposals

- Community involvement and user-oriented services
- Community systems strengthening
- Gender sensitive programming
- Services for adolescents who inject drugs
- Ensuring supportive legal and policy environment

The NFM and Harm Reduction?

- Critical concern about the impact of the allocation model on harm reduction in LMI and UMIC
 - Countries in Band 4 ('low' burden/high income)
 - Transitioning economies
- Diminishing external funding across the board (beyond the GF)

HUMAN RIGHTS BARRIERS TO HARM REDUCTION SERVICES FOR PEOPLE WHO INJECT DRUGS

Eliot Ross Albers, Executive Director, INPUD

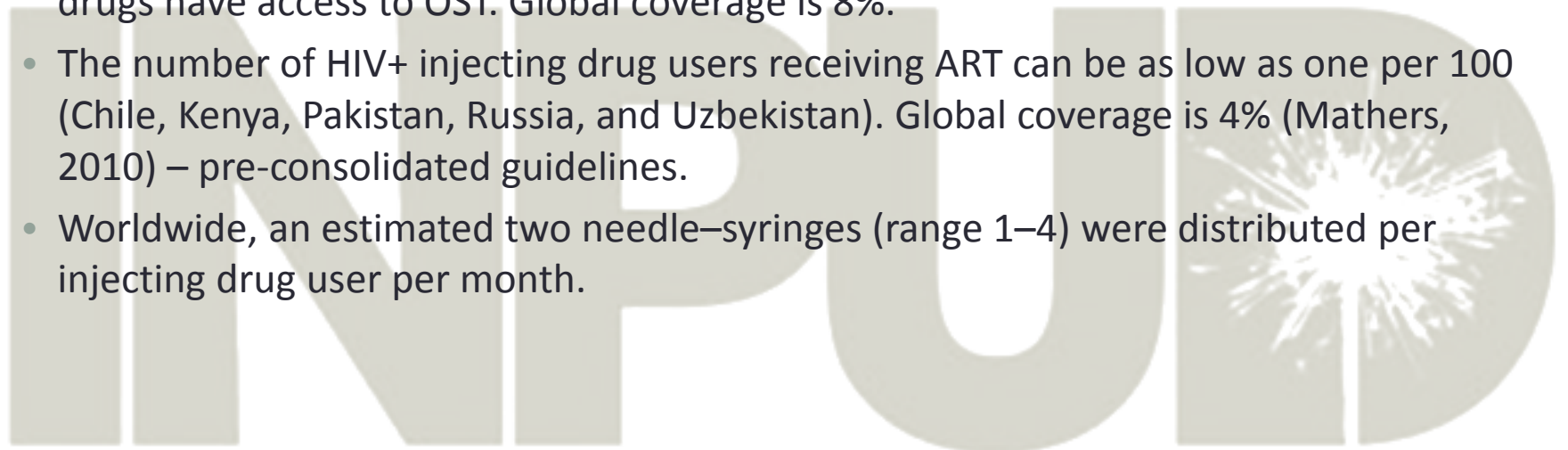
INPUD, MSMGF, CLAC, September 2014





Scene setting

- 16 million people who inject drugs globally in 148 countries, 90% of them in LI & MIC
- 3 million living with HIV: 18.9% prevalence. 20-40% in 5 countries, > 40% in 9 countries.
- 30% of new HIV infections outside SSA are amongst people who inject drugs, this is 10% of the global total
- Global access to harm reduction services is scandalously low.
- In central Asia, Latin America, and sub-Saharan Africa 1 in 100 people who inject drugs have access to OST. Global coverage is 8%.
- The number of HIV+ injecting drug users receiving ART can be as low as one per 100 (Chile, Kenya, Pakistan, Russia, and Uzbekistan). Global coverage is 4% (Mathers, 2010) – pre-consolidated guidelines.
- Worldwide, an estimated two needle–syringes (range 1–4) were distributed per injecting drug user per month.



Structural violence

“Criminalising drug use or imposing punitive measures against drug use has a disproportionate impact on the right to health of people who use drugs or are dependent on drugs. Moreover, the distinction between people who use drugs and people who are dependent on drugs is not followed in stringent drug control regimes. As a result, incarceration and/or compulsory treatment is often imposed on people regardless of their drug-dependent medical and health condition.”

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,

Anand Grover



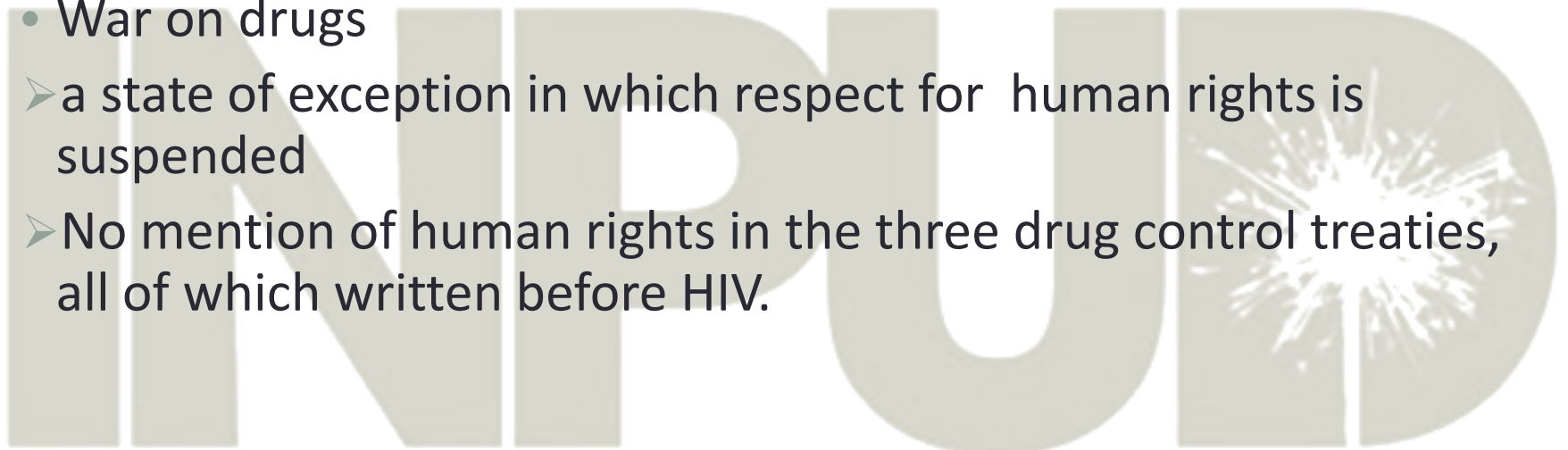
Structural violence, continued

- Human rights violations directed at people who inject drugs are systemically driven by global drug control conventions, and so any discussion of them must be predicated on an understanding of our status as a community living under a state of criminalisation and marginalisation of varying degrees of severity in its application.



Structural violence, continued

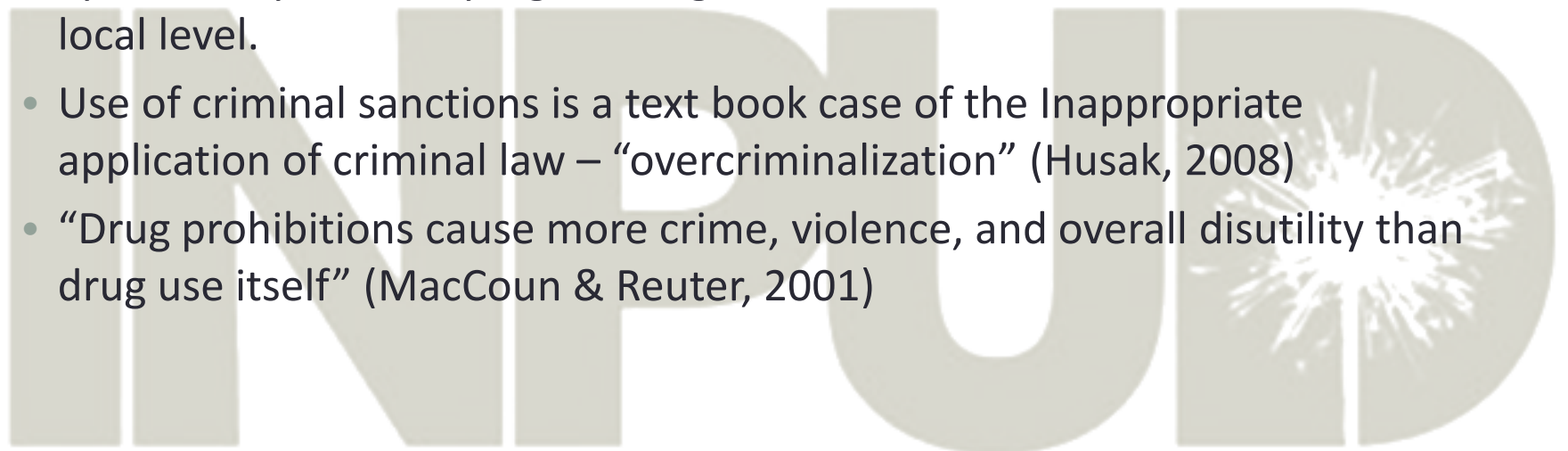
- Global punitive prohibition actively drives the production of harm, including human rights abuses – a global legal architecture composed of three conventions
 - 1961 Single Convention on Narcotic Drugs
 - 1971 Convention on Psychotropic Substances,
 - 1988 Convention Against Illicit Traffic in Narcotic Drugs
- War on drugs
 - a state of exception in which respect for human rights is suspended
 - No mention of human rights in the three drug control treaties, all of which written before HIV.





Rights and health

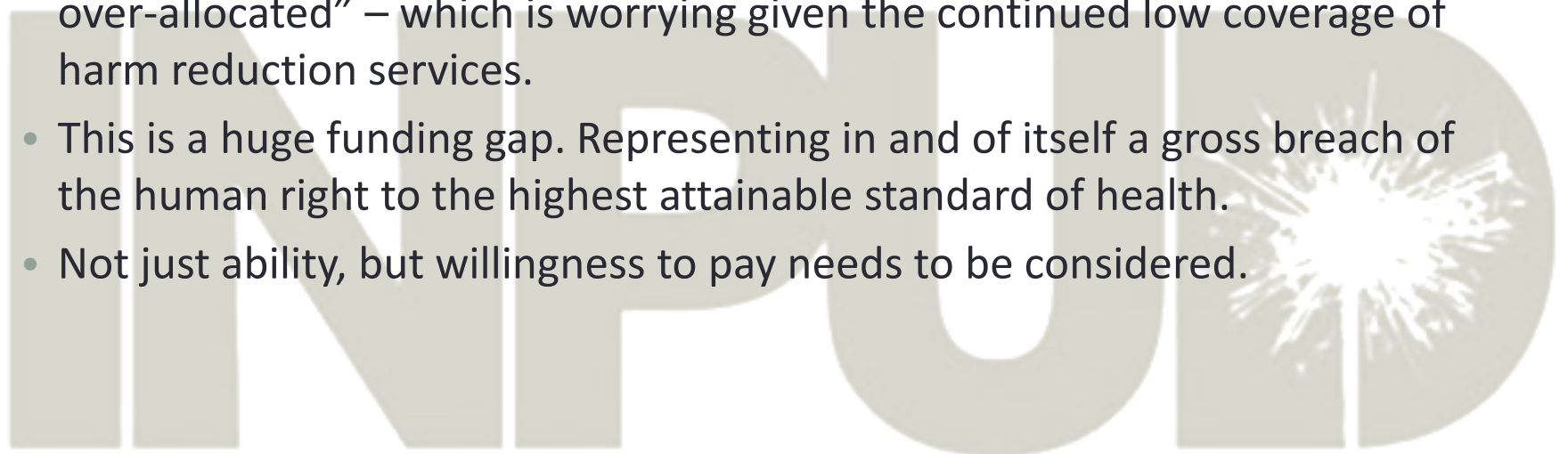
- “Human rights are more than ethical or moral imperatives – they are social determinants of HIV risk”, Strathee et al 2010
- Structural and legal reform is prerequisite of addressing systemic barriers to accessing health services, and dismantling key drivers of the risk environment.
- Rights violations against people who inject drugs are wide ranging, persistent, and well documented.
- Systemically driven by a global legal architecture, enforced at national, and local level.
- Use of criminal sanctions is a text book case of the Inappropriate application of criminal law – “overcriminalization” (Husak, 2008)
- “Drug prohibitions cause more crime, violence, and overall disutility than drug use itself” (MacCoun & Reuter, 2001)





Global fund as world's 'largest' harm reduction donor

- GFATM has over the course of its existence been the largest, often the only, donor to harm reduction programming.
- Of the 58 countries that have received harm reduction funding from GF in the past, 14 are now ineligible for NFM and a further 10 have not been allocated any 'new' money for the next three/four years.
- Furthermore, only 10 of these 58 countries are eligible for "incentive funding" (designed to support critical enablers).
- 26 of these 58 countries are referred to as "over-allocated" or "significantly over-allocated" – which is worrying given the continued low coverage of harm reduction services.
- This is a huge funding gap. Representing in and of itself a gross breach of the human right to the highest attainable standard of health.
- Not just ability, but willingness to pay needs to be considered.



Human rights barriers for people who inject drugs - background

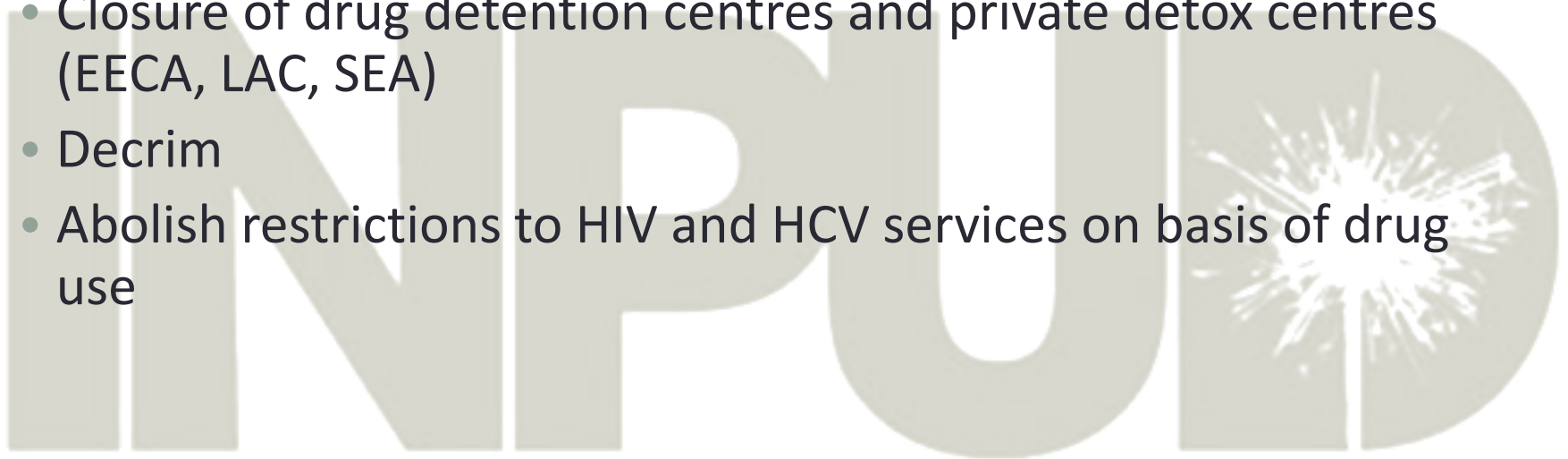
- Clear links demonstrated between human rights abuses experienced by PWID, vulnerability to HIV, HCV, and TB infection, & lack of access to health services.
- Nowhere in human rights law are PWID named as a group needing particular protections of their human rights. This might be necessary as global punitive prohibition systemically drives such abuses.

Abuses include, but are not limited to:

- Denial of harm reduction services (as well as barriers to, or denial of, ART and HCV treatment)
- Abusive police and law enforcement practices – quotas and easy targets. In Georgia a crackdown in 2007 led to 4% of the male pop. being forcibly drug tested, 35% imprisoned.
- Registries – in many EECA and SEA countries registries of PWID are kept. These keep people away from accessing services and can lead to denial of employment, travel, immigration, child custody,
- Coercion in the name of ‘treatment’, including drug detention centres, abuses in private detox centres. Recent INPUD study in Manipur found that 75% had heard of a death in a PDC, 95% had heard of forced returns after escape, 65% denied medicines, 25% chained.
- Women, sex workers and young people who inject drugs face extra barriers, and abuses. Sterilisation. Need to conceal pregnancy. Denial of access to services.

Rights based responses to HIV and drug use, include

- Access to justice services.
- Community empowerment
- Legal reform
- Funding scale up essential to achieve required level of harm reduction services
- Abolition of registries
- Closure of drug detention centres and private detox centres (EECA, LAC, SEA)
- Decrim
- Abolish restrictions to HIV and HCV services on basis of drug use



Removing barriers: increasing access, improving health, realising rights.

- “Social network, peer-led, and community mobilisation are effective in reducing HIV infection and improving access to HIV prevention, treatment, and care” (Latkin, 2009)
- These are all too rarely funded and in many countries drug user led organisations face legal barriers to organizing.
- Major legal and structural reform is prerequisite for creating an enabling legal environment in which to address the human rights violations faced by people who inject drugs and that have such a detrimental impact upon our health.
- UNGASS on Drugs, 2016



- “Networks of people who use drugs need to be empowered, engaged and seen as partners in addressing the epidemic” (*Malinowska-Sempruch et al 2010*)



Further reading

- ◆ Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies That Work*
https://static.squarespace.com/static/53ecb452e4b02047c0779e59/t/540da6ebe4b068678cd46df9/1410180843424/global_commission_EN.pdf
- ◆ Harm Reduction International, International Drug Policy Consortium (2014), *The Funding Crisis for Harm Reduction*
http://www.ihra.net/files/2014/07/20/Funding_report_%C6%92_WEB_%282%29.pdf
- ◆ International Network of People who Use Drugs and YouthRISE (2013), *The Harms of Drug Use: Criminalisation, Misinformation, and Stigma*
http://www.inpud.net/The_Harms_of_Drug_Use_JayLevy2014_INPUD_YouthRISE.pdf
- ◆ Médecins du Monde and International Network of People who Use Drugs (2014), *Nobody Left Behind: The importance of integrating people who inject drugs into HCV treatment programs* <http://www.inpud.net/201406-MDM-policy-VHC-en-NobodyLeftBehind.pdf>
- ◆ Global Fund to Fight AIDS, Tuberculosis and Malaria (2014), *Managing the Risk of Human Rights Violations in Global Fund Supported Programs*
http://www.theglobalfund.org/documents/humanrights/HumanRights_2014-05-22-Meeting_Report_en/

Thank you!

eliotalbers@inpud.net

International Network of People who Use Drugs
(INPUD) www.inpud.net





Network Development East Africa Webinar

Mick Webb

Programmes Coordinator

International Network of People who Use Drugs



Why do we do what we do ?

- **Legitimacy of services:** only if those they claim to serve are in fact having their expressed need to participate met.
- **The Denver Principles:** direct recognition of the structural causes of HIV transmission (criminalization, poverty, health needs, etc.) which in itself is powerful reason for involving users.
- High degree of **stigma and discrimination** towards drug users in the community; **their human rights** are often **violated**, especially in relation to health. This prevents an enabling environment for effective HIV responses among people who use drugs.
- An effective national network can highlight the **importance of advocacy** to enhance the achievement of expected outcomes for harm reduction interventions.



Professor Paul Hunt UN Special Rapporteur on the right to the highest attainable standard of health. In his report Professor Hunt stated 'This widespread, systematic abuse of human rights is especially shocking, because drug users include the people who are most vulnerable, most marginal in society.'



**East African region is virgin territory for
user organizing, with pilot harm
reduction projects facing considerable
resistance from local communities,
politicians, police, health authorities, and
media.
Kenya and Tanzania.**

Early lessons



Network development phase 1

Coastal region Kenya November 2013





- Following the 2013 November – network building placing ourselves at the heart of the maskani (drug using site) rather than using the facilities offered by the harm reduction pilot projects.
- Grassroots hierarchy approach placing the maskani members without IT/mobile phones, enduring chronic health issues, stigmatization, as the leading and most significant members of the mobilization.



'Nigeria' Eastland Nairobi

- Trusting our peers without reserve.
- 'Nigeria' is not a place to go without complete peer accompaniment and support.



The Mungiki are known as Kenya's most violent and notorious mafia/political/cult, and possibly one of the largest gangs in the world. The Kenyan police and army are kept out of the area, and the harm reduction projects outreach workers never venture inside. This is an area is called 'Nigeria'.



Our hosts in Nigeria. We trusted our
lives with our peers. We were
welcomed warmly



There was little knowledge of harm reduction information this deep into “Nigeria”, but there were just a few words from our hosts that were spoken that did have considerable impact.

“We have a choice now”

‘Nigeria’ community leader



- Taking workshops to the street and into the maskani has shown to be a key element in successful mobilisation.
- The Kenya Network of People who Use Drugs (KeNPUD)
- The Real Activist Community Tanzania (ReACT)
- The Tanzanian Network of People who Use Drugs (TaNPUD)

- The recent network development work in February 2014 in Nairobi, Kenya, is an extension of the developing community mobilisation model undertaken by the 2 EA country networks alongside INPUD while in Mombasa and along the coastal region of Kenya, during November 2013.



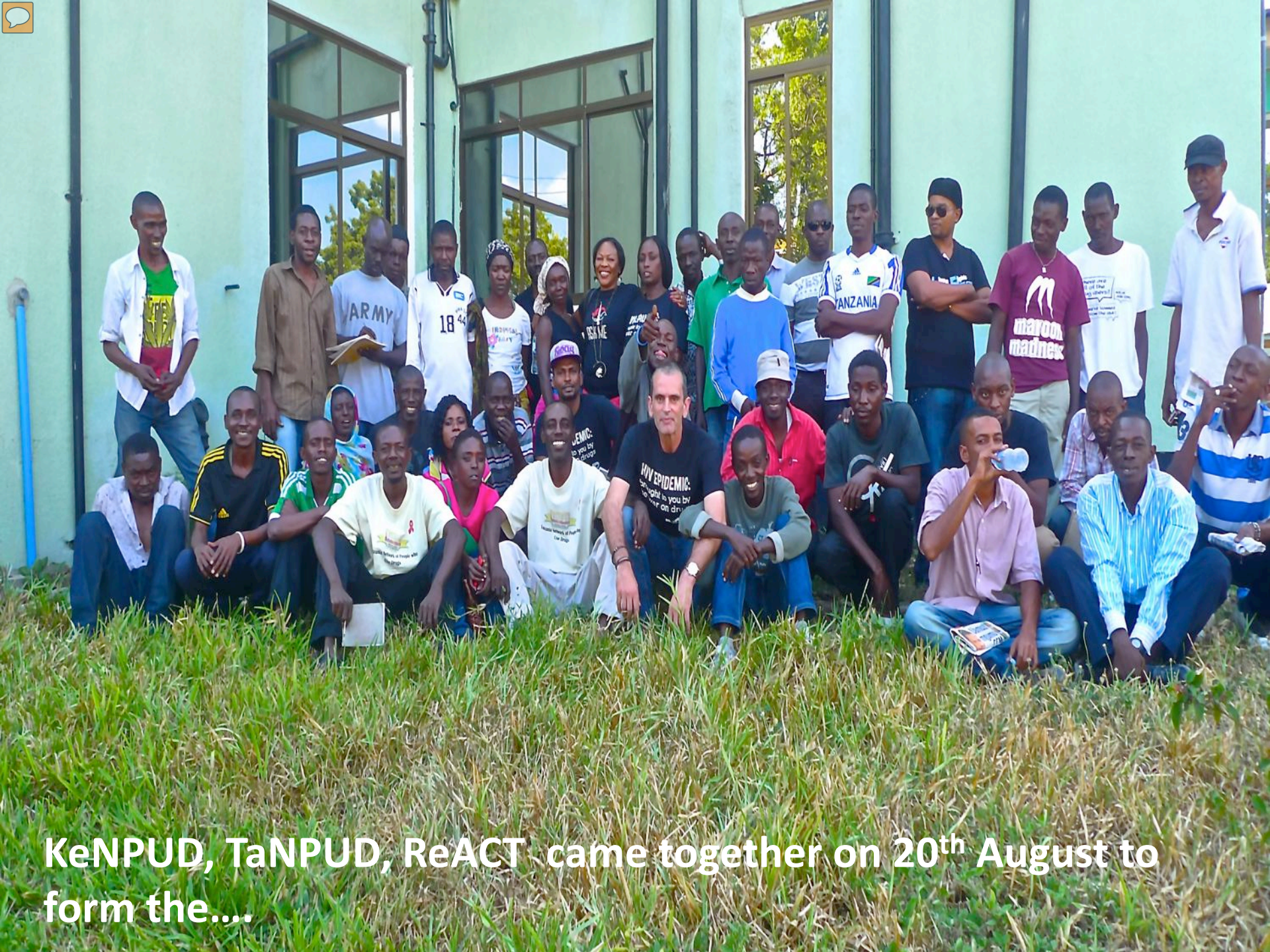
Stepping forward...

- To visit the communities directly and discuss the rights of people who use drugs and provide priority harm reduction information from a peer to peer basis.
- To raise awareness of the network aims and objectives and seed the discussions but leaving the communications to the country based network coordinators.
- To liaise with implementing partners to provide feedback from the site visits and share service users opinions on services.
- To speak with direct peers who have no interest in engaging with harm reduction



Stepping forward...





KeNPUD, TaNPUD, ReACT came together on 20th August to form the....

Msimbazi Declaration 20/08/2014

- On behalf of the Tanzanian Network of People who use Drugs (TaNPUD), it is my pride and honor to reaffirm our commitment to the Msimbazi Declaration of 20 August, 2014.
- Cooperation between TaNPUD, KeNPUD and ReACT is a fundamental strategic move in our ongoing endeavor to protect and advocate for the human rights of people who use drugs. We believe this is (and eagerly look forward to) the beginning of our journey towards the creation of an East African Drug Users Regional Network and the genesis of a continental African Organization of People who use Drugs (AFROPUD).
- You can count on our participation and involvement in this historic process of unity and growth.