

Inclusion and participation of people who use drugs in Global Fund processes: Report of findings from a Global Fund Community, Rights and Gender short-term technical assistance project

A report produced in the framework of the short-term technical assistance TA-LACLANPUD-2021 "Ensure the involvement and participation of people who use drugs (PWUD) in the processes related to the Global Fund funding cycle in the 11 countries of the ALEP multi-country project"

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Introduction

Background

There are approximately 5.5 million people who use non-injected drugs in Latin America and the Caribbean, while the number of people who inject drugs is low in comparison to other regions.^[1] This is largely due to the fact that, currently, injecting use is relatively rare outside Colombia, Mexico and Puerto Rico and because the rate of use of cocaine and its derivatives (which are commonly not injected) in the region is among the highest in the world.^[1]

As international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) withdraw from the region, the regional trend has been an increase in the proportion of harm reduction funding provided by national governments. However, domestic funding consistently falls short of what international donors have previously provided, leaving services without a sustainable source of finance and unable to provide continuous services to vulnerable populations.^[1] Additionally, the transition to domestic funding applies primarily to services for people who inject drugs, and there remain scarce funding opportunities for services for the majority of people who use drugs in the region who do not inject.^[1]

Since late 2019, the Latin American and the Caribbean Network of People who Use Drugs (LANPUD) is part of a multi-country project of the Alianza Liderazgo en Positivo (ALEP) financed by the Global Fund. The project is titled “Promoting Better Life Conditions and Human Rights for People Living with HIV and Other Key Populations through Integrated, Differentiated Services and Greater Resources to Support the Sustainability of the Regional Response to HIV”. Eleven countries in Central and South America participate in the project: Bolivia, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay and Peru.

Table 1: Representation of key populations on CCMs in 11 countries in Latin America and the Caribbean ^[5-7,13-18,21]

Country	People living with HIV	Men who have sex with men	Sex workers	Transgender people	People who use drugs	Other
Bolivia	✓	✓	✓	✓	✗	
Colombia	✓	✓	✓	✓	✗	
Costa Rica	✓	✓	✓	✓	✗	
Ecuador	✓	✓	✓	✓	✗	
El Salvador	✓	✓	✓	✓	✗	
Guatemala	✓	✓	✓	✓	✗	Indigenous people
Honduras	✓	✓	✓	✓	✗	
Nicaragua	✓	✓	✓	✓	✗	
Panama	✓	✓	✓	✓	✗	Indigenous people
Paraguay	✓	✓	✓	✓	✗	
Peru	No data	No data	No data	No data	No data	

During the first year of the project, LANPUD noted that people who use drugs are not represented inside Global Fund Country Coordinating Mechanisms (CCMs) in the region (see Table 1). This is despite people who use drugs being at elevated risk of HIV. In this context, LANPUD proposed a project under the Community, Rights and Gender Technical Assistance Mechanism of the Global Fund. The objective of the technical assistance is to:

- Ensure the involvement and participation of people who use drugs in processes related to the Global Fund funding cycle in the eleven countries of the ALEP project.

The sub-objectives are:

- To create a diagnostic of the involvement of people who use drugs in processes related to the Global Fund in eleven countries where the ALEP project is carried out.
- To create an advocacy strategy in CCMs to guarantee the participation of people who use drugs in Global Fund processes.

This report represents the completion of the first sub-objective.

Methodology

Data for this report was gathered through a qualitative multi-stakeholder consultation through questionnaires and interviews. The sample of stakeholders was selected through consultation with the technical assistance applicant (LANPUD), regional experts, Harm Reduction International, and the Global Fund (from the Community, Rights and Gender unit and the CCM Hub. Interviews were conducted with staff at the Global Fund (five participants), representatives of LANPUD (four participants). Questionnaires were distributed to representatives of CCMs (ten participants in ten countries) and other regional key population networks (six participants). Data was analysed through inductive thematic analysis by the research team. More details on methodology and research instruments can be accessed by contacting the research team.

Findings

Part I: Global Fund Country Co-ordinating Mechanisms and Key Population representation

Key populations in Country Co-ordinating Mechanisms: “Nothing about us without us”

Country Co-ordinating Mechanisms (CCMs) are “national committees that submit funding applications to the Global Fund and oversee grants on behalf of their countries”. They are the principle means through which countries can access Global Fund financing for the response to HIV, tuberculosis and malaria. According to staff at the Global Fund’s CCM Hub, and documents outlining the role of CCMs, they are governed by three basic principles: ^[2,3]

- Accountability: The need to monitor the implementation of grants and ensure that principal recipients meet targets.
- Transparency and inclusion: Developing and implementing clear processes and ensuring balanced representation in the CCM of government, civil society (including key populations) and international and multilateral organisations.
- Country ownership: The right of national bodies to define their own priorities in the response to HIV, tuberculosis and malaria.

Civil society is universally recognised by Global Fund staff and in published documents as an essential component of CCMs. The CCM Policy – the document outlining the principles and requirements for the functioning of CCMs – identifies eight categories of civil society representation that might be included in the membership of a CCM, including Key Populations.^{1[2,3]} It is a requirement that key populations are represented in CCMs “based on epidemiological as well as human rights and gender considerations.”^[2,3] The Global Fund’s definition of a key population is a group that meets each of the three following criteria:

- “Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the three diseases [HIV, tuberculosis and malaria] – due to a combination of biological, socioeconomic and structural factors.
- Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group.

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1 The others are: watchdog organisations, women and girls, children and young people, experienced international non-governmental organisations (NGOs), experienced national NGOs, charitable organisations, and academia.

- The group faces frequent human rights violations, systemic disenfranchisement, social and economic marginalisation and/or criminalisation – which increases vulnerability and risk and reduces access to essential services.”

In interviews with Global Fund staff, CCM representatives and civil society actors, there was broad agreement that key populations have an important role to play in CCMs. Their inclusion not only ensures that they can represent their interests in an important policy forum,^[2,4–10] but was also noted to improve the quality and effectiveness of interventions overseen by the CCM.^[4,11] As put by two interviewees, emphasising the importance of empowering key populations to demand their rights: “nothing about us without us”.^[10,12]

However, there are practical limits on the participation of civil society and key populations in CCMs. Firstly, Global Fund staff emphasised the importance of balance between governmental and civil society representatives, and the risk that overloading CCMs with civil society would lead to a “laundry list” of demands and lose the engagement of government.^[2,9] Secondly, a “healthy” size for a CCM is deemed to be around 12 to 20 people, meaning that not every population or sector of civil society can be represented and there is a need for prioritisation and collaboration.^[2,4,9]

As a result, the process of selecting civil society representatives is a vital moment to influence the composition of the CCM. In the majority of CCMs surveyed, civil society members are elected from among the civil society organisations affiliated to the CCM.^[5–7,13–18] These are moments of significant opportunity and risk: usually half of the membership will be up for election at once, at which point progress can be made or lost.^[2] A lack of renewal of membership can lead to inflexible, unrepresentative and conservative CCMs, as noted in Paraguay by one civil society interviewee.^[19]

In order to be eligible to receive funding from the Global Fund, CCMs must comply with regulations, including on the participation of key populations. This is reviewed when they apply for funding (normally every two to three years).^[4,9,10] However, due to the commitment to country ownership of CCMs, the Global Fund permits countries to define which key populations should be prioritised for representation based on the national experience of HIV, tuberculosis and malaria.^[2] Under current rules, the Global Fund cannot compel CCMs to include a certain key population, as suggested by one interviewee.^[12]

In cases where a CCM has no key population representatives, the Global Fund has legitimacy mechanisms to work with CCMs to comply with regulations. The Eligibility Requirement and Performance Initiative collects indicators on the participation of civil society and key populations in CCMs. Where it finds a lack of representation, the Global Fund will firstly give the CCM time to fix the issue

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At the international level, the Global Fund has made it clear that people who use (but do not inject) drugs are in fact a key population for HIV. According to the Global Fund, the decision on which key populations should be prioritised at the national level for representation on the CCM should be taken in line with national priorities in the response to HIV, tuberculosis and malaria.

(an interviewee suggested one year). Ultimately, if CCMs do not address the issue in the time frame, the Global Fund can prevent them from applying for funding entirely.^[2] A new programme by the CCM Hub for monitoring CCMs was launched in 2019, seeking to promote not only the balanced representation of key populations, but also the quality of that representation. It works in close collaboration with the Community, Rights and Gender department of the Global Fund.^[2,10]

People who use drugs and the Global Fund mandate

At the international level, the Global Fund has made it clear that people who use (but do not inject) drugs are in fact a key population for HIV. This is documented in their Technical Brief on Harm Reduction, Technical Brief on HIV and Key Populations, and Modular Framework Handbook. This is particularly true in relation to people who use drugs and are experiencing homelessness.^[20]

According to the Global Fund, the decision on which key populations should be prioritised at the national level for representation on the CCM should be taken in line with national priorities in the response to HIV, tuberculosis and malaria.^[2,4] This should be “based on epidemiological as well as human rights and gender considerations”.^[2,3] According to one staff member, this allows the Global Fund to avoid politics and “focus on data”, rather than specific lists of populations.^[4]

An example given by a member of staff at the Global Fund was Mozambique. There, adolescent women are prioritised for HIV funding because of the shape of the HIV epidemic in that country, even if not explicitly listed as a key population in the Global Fund definitions.^[4] Additionally, prevalence of HIV is not the only factor: a population can be prioritised based on a greater risk of HIV due to living circumstances, behaviours or challenges in accessing health services (such as stigma and discrimination).^[2,10]

CCMs, Global Fund staff and civil society all report that people who use drugs face barriers to accessing health services and are (at least in some cases) more vulnerable to HIV acquisition. They are a key population, with regard to HIV.

As demonstrated by Table 1 (see p.1), at present no CCM in Latin America has any representation of people who use drugs. When surveyed, CCM representatives universally cited the belief that there is not sufficient evidence for a link between people who use drugs but do not inject and vulnerability to the diseases concerning the Global Fund, and that they are therefore ineligible for representation.^[5–7,13–18,21] Civil society and Global Fund actors also identified the lack of data as the primary barrier to the participation of people who use drugs.

However, when it comes to people who inject drugs (a sub-population of people who use drugs) there is broad consensus that they should be considered a key population. This is supported by a well-established evidence base of the links between HIV and injecting drug use, together with recognition at the international level by UN agencies and the Global Fund.^[2,22] In Colombia, the CCM has received funding for HIV prevention and programmes to reduce stigma and discrimination among people who inject drugs.^[4,21,23] A representative of the Colombian CCM reported that they are actively seeking to establish links with people who inject drugs in the country.^[21] Despite this commitment, people who inject drugs are not currently represented on the CCM (a single seat is shared by female sex workers, people experiencing homelessness and people who inject drugs; it is occupied by a representative of female sex workers).^[12] That people who inject drugs are not represented in Colombia, despite strong evidence that they are vulnerable to HIV, indicates that the absence of data may not be the defining barrier to the inclusion of people who use drugs in CCMs.

In the other ten countries in this study, people who inject drugs do not represent a significant proportion of people who use drugs.^[1,20] As a result, they are not prioritised for funding and therefore representation on CCMs. This includes being omitted from CCM statutes defining which key populations must be represented. In several countries statutes would have to be reformed to redefine key populations and permit the representation of people who use drugs (reported in Costa Rica, Ecuador, Guatemala and Panama).^[6,7,17,24]

In Ecuador, a CCM representative reports that there was an open process in 2020 to determine if people who use drugs should be included as a key population, but that it was decided that there was not enough evidence.^[13] They added that only populations served by Global Fund grants should be included, in order to avoid “conflict” between key population groups.^[13] However, a civil society interviewee contradicted this, reporting that the CCM in Ecuador was inflexible and made no effort to update their statutes and include people who use drugs.^[24]

Civil society, CCMs and representatives of people who use drugs agree that there is a grave lack of data on the link between HIV and non-injecting drug use.^[4,8] In order to prioritise a population, it is necessary to know its size, and the prevalence of and vulnerability to HIV.^[4] However, not only is there little data, there have been few efforts by governments or CCMs to obtain data or consider thoroughly the data that is available.^[17,20,25] This creates a self-reinforcing cycle: the absence of data means no representation or empowerment, and the absence of representation means there are few opportunities to advocate for data collection.^[20] It also means that in cases where CCMs have submitted proposals related to people who use drugs, they have been unsuccessful (such as in applications to the Covid-19 Response Mechanism in Costa Rica and Guatemala).^[6,7] There is a strong need for technical partnerships (for example with the World Health Organisation) to gather data on HIV among people who use drugs, as well as with other researchers and

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non-governmental organisations in the region.^[2] These may be led by either CCMs or networks of people who use drugs themselves, though resources remain a challenge for the latter.

The fact of not recognising people who use drugs as a key population also affects the collection of data. One civil society interviewee raised concerns that it may result in unreliable data: for example, if a person uses drugs but is also a man who has sex with men, he will likely only be recorded as a man who has sex with men in HIV data.^[12] As such, it is important to recognise and investigate the role of intersectionality between key populations, for example the role of drug use in HIV among other key populations.^[23] This is compounded by stigma and self-stigma, which may lead to people not reporting their drug use in HIV settings, and therefore the relationship between drug use and HIV going unreported.^[12]

To underline the importance of data, CCM representatives in several countries (Bolivia, Costa Rica, Honduras and Nicaragua) explicitly stated that if data showed that people who use drugs are at greater risk of HIV, they should be included as key populations and entitled to representation in the CCM.^[5,6,15,16]

Accessibility of health services and a human rights lens

In its guidance on the definition of key populations, the Global Fund does not focus exclusively on the prevalence of HIV, tuberculosis and malaria. It explicitly includes “human rights considerations”^[3] and accessibility, stigma and discrimination as factors to consider.^[10,26] Even if prevalence of HIV was found to be low among people who use drugs, Global Fund guidance can still promote their inclusion in CCMs.^[9] A sole focus on prevalence data does not capture the real challenges and vulnerability to HIV of people who use drugs.^[4,20]

People who use drugs face criminalisation, stigma and discrimination when accessing health and social services, making them particularly vulnerable to HIV. In this study alone, this was raised unprompted as an issue in Costa Rica, Ecuador, Honduras and Paraguay.^[12,15,20,24] This presents a significant barrier to the accessibility of these services, and according to Global Fund staff and the Colombian CCM this should be a factor in defining key populations.^[2,4,21] In fact, this has been recognised with regard to men who have sex with men and transgender people in Costa Rica, despite applying equally to people who use drugs.^[20] Communities should make this barrier to health care more visible to CCMs. This can be done in the short term, while the community advocates for resources to gather data on the prevalence of HIV among people who use drugs.^[20,27]

Across the countries in this study, civil society and CCM representatives also reported that people who use drugs are excluded from CCMs and other policy processes due to criminalisation, stigma and discrimination.^[5,12,15,17,19–21,24,25] In the

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words of Global Fund staff members, CCMs may not believe that people who use drugs can “bring anything to the table.”^[4,10] This means that representatives of people who use drugs must not only demonstrate to CCMs that they experience stigma, but also challenge the stigma emanating from CCM members themselves. There must also be a recognition that people who use drugs may be putting themselves at risk by openly representing their population, particularly in environments where there is robust criminalisation of drug use.^[2,10,12] This relates to the perception in some countries, as noted by CCM representatives in Guatemala and Nicaragua, that drugs are an issue for the police and criminal justice system, rather than the HIV sector.^[7,16] However, the experience of other key populations challenges this: for example, men who have sex with men were represented on the CCM in Haiti while homosexuality was still illegal.^[9] Equally, it must be taken into consideration that CCMs may be unable to take strong political stances that are in opposition to national criminal justice policy.^[20,27] CCMs, civil society and the Global Fund must cooperate to ensure that these factors do not impede the representation of key populations in CCMs.

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Part II: Mobilising key populations for effective representation

Mobilisation through organisation

In addition to the absence of data, another key reason cited by CCMs for the lack of representation of people who use drugs is the lack of organisation and leadership of people who use drugs at the national level. This was mentioned in by CCM representatives in Bolivia, Colombia, Ecuador, El Salvador, Guatemala, Honduras and Panama, and by civil society in Costa Rica and Paraguay.^[5,7,12-15,17,20,21] Many CCMs reported that they are unaware of any organisation of people who use drugs in their country, and asked that representatives introduce themselves to the CCM as a first step in engagement.^[5,7,8,13,21,24] This was echoed by staff at the Global Fund, who reported that networks of people who use drugs need to engage in “public relations” in order to raise their profile in CCMs.^[4,10] The Community, Rights and Gender department of the Global Fund may be an important partner in doing this, and both key population groups and the department should actively work towards greater organisation.^[2,10]

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In some cases, in order to participate in CCM elections and CCMs themselves, organisations must be legally incorporated (noted explicitly in El Salvador and Honduras).^[14,15] However, in some cases stigma and criminalisation may make formal organisation impossible or unfeasible, in which cases Global Fund interviewees emphasised that key populations should still seek to organise and have a collective voice heard.^[4] Relatedly, it is important that these organisations – whether formal or informal – are able to demonstrate their legitimacy as representatives of the community of people who use drugs.^[15] They must be able to unite any pre-existing networks and organisations in order to present a united voice.^[24]

“Do not expect everything to come at once, but have more of a strategic vision”^[2]

Even when organised, there are few formal procedures people who use drugs can follow to guarantee representation in CCMs, because of the Global Fund’s commitment to country ownership (the principle that country should determine their own priorities in the response to HIV, tuberculosis and malaria, see p.2).^[2,4] This means organisations must have a structured advocacy plan with objectives for the short, medium and long term.^[2,4,20,25] Both civil society and the Global Fund staff emphasised that this means having a clear idea of their aims and demands.^[2,4,20] Organisation across international borders can also support this through the sharing of best practices and lessons learned.^[2,20] With regard to the Global Fund, strategic advocacy includes engagement at every opportunity with CCMs and making sure they are aware of the needs of people who use drugs. Firstly, this requires establishing open communication with CCMs, to ensure people who use

drugs are aware of open consultations and opportunities for influence without representation within CCMs.^[6,8–10,12,25] Secondly, it means being pro-active in education and engaging CCM members, demonstrating the value of representation of people who use drugs, for example through talks and webinars.^[4,10,20] Thirdly, several Global Fund respondents emphasised participation in strategic monitoring as a further way of influencing CCMs.^[2,7,9,10,24] This allows communities to have direct influence in the assessment of programmes that should be serving people who use drugs as a population vulnerable to HIV.^[2]

CCM representatives, Global Fund staff and representatives of other key populations also noted the importance of engagement in non-Global Fund policy processes as a way of establishing legitimacy and raising awareness.^[2,4,9,12,20,21,24] One civil society interviewee cited the success of the cannabis movement in Ecuador as an example, where engagement in local and national policy processes enabled them to raise their profile without formal representation.^[24] Participation at the national level, such as in national HIV policy bodies,^[12,20] may also be a longer term option as countries transition out of Global Fund financing.^[4] This can also work in the opposite direction: in some cases CCMs may be the basis for future national government bodies.^[4]

“Active and effective representation”^[4]

Of course, “a seat at the table”, whether in a CCM or another forum, is not sufficient in itself. Representation must also be effective in promoting the interests of people who use drugs.^[4] In order to support this, organisations must be able to build technical capacity.^[2,4,11,13,15] This includes computer skills, policy and political expertise, accountability and grant writing.^[2,11,13,15] Importantly, representatives from three CCMs (Bolivia, Nicaragua and Paraguay) expressed that CCMs themselves could do more to support capacity building among key populations.^[5,16,18]

Actively engaging with the CCM Hub, the CCM Evolution project and the Community, Rights and Gender department can support capacity building, with all three entities increasingly seeking to work with key populations to support their organisation and increase their participation in Global Fund processes.^[2,4] Furthermore, the Global Fund offers training modules for people engaging with CCMs through the iLearn platform.^[2] This includes courses on “Country Coordinating Mechanism orientation”, which includes ten modules covering the role, purpose, remit and organisation of CCMs. Indeed, in Ecuador, it is a requirement that CCM members take this course.^[2] As emphasised by other Key Population representatives, it is vital that people who use drugs seeking representation on CCMs are autodidacts and actively seek out opportunities to increase their expertise and technical capacity.^[25]

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Mobilisation through bridge-building and intersectionality

Alongside organisation within the community of people who use drugs, many respondents also emphasised the importance of engagement with other key populations. It was also noted that, among the three diseases financed by the Global Fund, the HIV community is the best organised, including the relevant key populations.^[2] There is already evidence of strong solidarity: a representative from the Latin American Network of People who Use Drugs said, “People who use drugs must demand their participation as a right. They have the support of [the network] to demand this right.”^[11] In order to take advantage of this, organisations of people who use drugs must again have a strategic plan for communicating with other Key Populations.^[25]

According to both Global Fund staff and CCM representatives, key population delegates in CCMs should not only represent their own peers, but all key populations.^[2,4,9,13-15] This means people who use drugs should not only rely on securing in-person representation, but must also build effective communication with the people already sitting on CCMs from other communities, such as Transgender people, men who have sex with men and sex workers. In several CCMs, representatives reported that improvements in communication with representatives may improve the influence of those populations that are not directly represented.^[13-18,27] One case of good practice cited was in El Salvador, where representatives of people living with HIV have set up a Whatsapp group as a system of consultation and to share information.^[14]

However, this approach has drawbacks. Firstly, only people who use drugs have direct experience and knowledge of the challenges they face in accessing good health.^[20] As a result, other populations may not sufficiently prioritise the needs of people who use drugs, as is documented in Bolivia.^[5] While people from other key populations may use drugs, that does not necessarily mean that they are able to represent the interests of people who use drugs as a community (particularly where they have a mandate to represent another key population). Secondly, other key populations may have stigmatising attitudes towards people who use drugs, and therefore may not wish to represent their interests; for example, this is observed in Costa Rica and El Salvador.^[12,20]

In some cases, key population representatives may not consider themselves to have interests aligned to those of people who use drugs.^[9] As such, another strategy to mobilise other key populations in the interests of people who use drugs may be to emphasise intersectionality and common interests. Highlighting the role of drug use in the vulnerability to HIV of other populations, such as Transgender people, sex workers and men who have sex with men, may be a tool to persuade CCMs to prioritise interventions for people who use drugs.^[4,6,18,24] This can be especially effective where there is more data on HIV epidemiology among these populations, and therefore possibly data on the role of drug use.^[4,24,25] In some

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cases, emphasising this intersectionality and working with other populations to understand it can also be a tool to persuade other Key Population representatives of the relevance of people who use drugs to their mandate and interests.^[4,12]

For example, one individual in Ecuador was rejected as a CCM member when presented as a representative of a cannabis organisation, but the same individual was later accepted as a representative of an organisation working with sex workers, men who have sex with men and transgender people. This intersectional experience of members can be vital in securing representation of people who use drugs.^[24]

However, it is important not to overestimate the role of intersectionality, as noted by one civil society representative. People from other key populations using drugs are not necessarily good representatives for people who use drugs as a community, and it is important to maintain an independent identity for people who use drugs as a key population with specific needs.^[20] Relatedly, in some cases CCM representatives and Global Fund staff appeared to conflate people who use drugs with people deprived of liberty and people experiencing homelessness.^[2,5,7] Despite some overlap in these populations, they remain distinct identities with distinct interests. This is why it is important for networks of people who use drugs to have a clear definition of who they seek to represent, and to retain the ambition for people who use drugs to have genuinely representative participation in CCMs and other policy bodies.

Conclusions

People who use drugs entirely lack representation in CCMs in the 11 countries studied in this technical assistance project. As a result, they are deprived of this forum to make the case for Global Fund investment in programmes for their population. The lack of representation is strongly associated with the lack of recognition that people who use drugs are a key population in the response to HIV and tuberculosis in the region.

As expressed in the findings presented here, there are two important means of demonstrating that people who use drugs (including non-injected drugs) are a key population. Firstly, there is a need to gather evidence on HIV and tuberculosis among people who use drugs, including not only data on prevalence but also data on threats to accessibility of services such as stigma, discrimination and criminalisation. Secondly, there is a need to strengthen the organisation of people who use drugs and their co-operation with other key populations, in order to ensure their voices are heard in all relevant fora.

The Global Fund (including the Community, Rights and Gender department and the CCM Hub) and the CCMs themselves also play an important role in ensuring people who use drugs are represented in these processes. While the Global Fund has made key steps towards this globally, research participants identified several ways in which their impact can be strengthened. Firstly, the Global Fund and CCMs can actively engage with networks of people who use drugs once contact is established, for example by inviting them to participate in open policy processes. Secondly, they can support efforts to understand HIV and tuberculosis among people who use drugs, including data collection on prevalence and service accessibility. Thirdly, they can support capacity building for organisations of people who use drugs and other key populations, including ensuring they have access to training materials. All of these actions are particularly important in contexts where the participation of people who use drugs is limited by stigmatisation, discrimination and criminalisation.

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