Model description of innovative interventions of harm reduction programs in Global Fund Grant Cycle 7

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1. PEER COUNSELING ONLINE

INTERVENTION AND KEY ACTIVITIES - key activities are suggested, based on the publication "Recommendations for setting up online harm reduction services"[1]

- Conducting a community assessment;
- Choosing target population and identifying its needs;
- Setting SMART goals and objectives for the programme;
- Identify activities, methods, and online platforms for achieving goals and objectives;
- Establishing contact with administrators of online platforms and familiarizing with their Terms of Service;
- Development of relevant, engaging, and culturally competent content;
- Development of the organizational guidelines for online peer counseling (step-by-step procedures how it should be organized/ conducted, privacy policy);
- Recruiting peers, based on target population identified;
- Series of training for peers, who will be counseling online;
- Mentorship/ supervision for peers, who are counseling online;
- Develop a risk mitigation plan;
- Report programme data.

PRIORITY POPULATIONS - people who use drugs, new psychoactive substance users, young people who use drugs.

BARRIERS AND INEQUITIES - criminalization, stigma, discrimination, and geographic restrictions limit access to harm reduction services, including peer counseling. As a result, rural populations in many countries and regions are underserved. In addition to geographic gaps in services, there are subgroups of people who use psychoactive substances who have difficulty accessing harm reduction services because these services are not tailored to their specific needs. For example, a cross group of young people who use NPS frequently communicate with each other and find various psychoactive substances online: on drug sales sites, online forums, and instant messengers. The changing drug scene, COVID-19, and many other factors are influencing the way drugs are sold and bought today, and relevant changes. The online space is becoming increasingly important. When drug dealers go online, people who use psychoactive substances follow them, not only to buy drugs, but also to communicate and support each other. This means that where it is most convenient for them, they can also get important information, share personal experiences, life hacks, resources and so on. Therefore, peer-to-peer counseling should be offered on online platforms where people who use psychoactive substances share information and communicate.[2]

RATIONALE - the drug scene in the world has changed a lot in the last decades, and these changes continue[3]. Some time ago, peer counselors were most effective in places where drugs

[1] https://ehra-uploads.s3.eu-central-1.amazonaws.com/c53fbd4d-3d18-47cd-ac0f-608dfb8448f4.pdf
[2] https://www.unodc.org/res/hiv-aids/new/publications_drugs_html/RecommendOutreachENG.pdf
[3] https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html

are sold, such as drug dealers' homes, "hangouts", and other scenes where people who use drugs gather. Now, these processes are increasingly taking place on the Internet. These changes were strongly influenced by the pandemics of COVID-19.

Online peer-to-peer counseling can be useful for reaching people who use psychoactive substances but do not access and/or use harm reduction services for a variety of reasons. Around the world, we see that access to traditional harm reduction programs is increasingly limited, especially for young people and users of new psychoactive substances (NPS). Therefore, online harm reduction can be an effective way to inform and educate people in their private settings.[4]

The main goal of online peer-to-peer counseling is to provide help on online platforms based on one's life experience in the harm reduction field. One or a series of counseling sessions is intended to help the person with their health and safety issues and concerns. Objectives of online peer-to-peer counseling are:

- increasing motivation for positive change;
- improving life safety;
- building interpersonal relationships with others;
- providing information about social and psychological issues;
- peer training;
- providing referrals to specialists in medical, social, legal, and other areas;
- reducing self-stigma among people who use drugs.

The purchase and sale of NPS in Eastern Europe and Central Asia is done mainly through websites (including Darknet marketplaces), social networks such as VKontakte, Odnoklassniki and Facebook, and various messengers such as Telegram, Viber, WhatsApp. In addition, people who use drugs use the above online platforms to communicate with each other, including on issues related to maintaining health while using drugs. This opens opportunities for service providers to conduct outreach and harm reduction interventions online.

EXPECTED INVESTMENT[5]

- Necessary infrastructure (such as computers, tablets, or smartphones; uninterrupted and secure internet access; membership fees for certain platforms; and VPN and TOR browser if you plan to conduct web outreach on the darknet.);
- Human resources (such as Project manager, online peer-outreach workers, mentor/ supervisor for peers, M&E consultant);
- Initial few days' workshop to define programme;
- Training series for peers, who will be providing online counseling;
- Development of relevant, engaging, and culturally competent content (preparation of information, design of leaflets, videos, etc.)
- Development of the organizational guidelines for online peer counseling

[4] https://www.hri.global/files/2020/12/08/GSHR_2020_Eurasia_Russian.pdf
[5] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

- Motivational harm reduction package for clients (content of package should be developed based on the local realities/ needs of people who use drugs).

2. DRUG CHECKING

INTERVENTION AND KEY ACTIVITIES

- Assessment of the local needs for drug checking services (current drug scene, analysis of legal barriers to access/ provide drug checking services, route of administration, overdose rate, rate of HIV and other infectious diseases among key population)
- Ensuring partnerships with national laboratories, universities or harm reduction programmes that have already the legal arrangements and testing technologies to jointly run drug checking services. Special agreements with national local authorities should be arranged in advance to ensure a safe working environment and allow people who use drugs to freely and anonymously submit drug samples for testing.
- Advocacy efforts should be focused to create a supportive environment to recognise drug checking service as a harm reduction component and to include it in the framework of National Strategies (HIV/AIDS, Drug or Health Strategies), National Action Plans or Local Health Strategies.
- Selecting drug checking method (identifying purpose of the service, selecting technology, which will be used to analyse samples).
- Developing protocol for the drug checking services and agreeing it with MoH and/ or other key stakeholders. Standard Operating Procedures (SOP's), workflow symbols and protocol/service rules must be designed in a way to ensure a safe and healthy workplace for staff and clients.
- Piloting drug checking service
- Analysis of pilot drug checking results
- Advocacy and awareness raising campaigns using different communication channels must be organised. Advocacy efforts must be focused to inform the audience to understand the concept of drug checking services as a harm reduction component, its benefits in terms of overdose prevention and monitoring of drug markets, as well as a connection/referral bridge to other socio-healthcare services.
- Communicating test results and harm reduction strategies: the final aim of the programme is to attract people who use drugs to know the content and purity of a substance to avoid overdose, provide counseling and also to encourage them to re-visit the service. To be successful, several factors should be considered, such as the provision of services in appropriate settings, results to be given in a few minutes, ensuring the safety and anonymity of consumers, and counseling and harm reduction information to be given in an appropriate manner and setting. Another effective way to inform clients and the general public is through the front-facing system where anonymous and confidential information on test results is given using colour-coded boards.

PRIORITY POPULATIONS - People who use drugs, including young people who use drugs and recreational drug users, as well as other populations, keeping in mind intersectionality.

BARRIERS AND INEQUITIES - legal restrictions, fear of criminalization and policies that encourage police enforcement practices are identified as the most common barriers. The lack of sustainable funds, trustworthiness and staff expertise are also identified as barriers that critically affect the programme quality and utilization of drug checking services.

Even though some countries of the CEECA region are adapting their legislation and policies to support harm reduction programmes, the environment still remains harsh with policies focusing

more on supply reduction and laws that criminalize people who use drugs. According to current legislation, if implemented, drug checking services will operate in a grey legislative area, meaning that there is fear of the legal consequences in running a drug checking service. These fears include restrictions in programme staff handling, or being in direct contact with, submitted drugs for analysis and fear of criminalization by drug users who may be subject to legal repercussions once visiting the programme. On the other hand, drug checking equipment and supplies under current legal frameworks may be easily interpreted as drug paraphernalia, and either the programme staff or the drug users are at risk of being criminalized for allegedly facilitating drug consumption. In the CEECA region, most countries concentrate their efforts on demand and supply reduction through encouraging "enforcement-based policing practices", resulting in high levels of monitoring, searches and stops in areas where harm reduction program operate or where there is a flux of people who use drugs. In turn, such practices are contextual barriers that discourage people who use drugs from utilizing harm reduction services. Legal restrictions and fear of criminalization have also been noted as key barriers even by harm reduction service providers during virtual meetings.

Compared with the experience of funding harm reduction services where different mechanisms are in place to ensure their operation, many drug checking services operate without significant government funding. Funds are mostly generated by short-term external sources, such as donor agencies or self-funded by volunteer donations. In cases where these initiatives are supported by government resources, mostly from the Ministry of Health, it is hard to realize the funding model and taxonomy.

The mode of operation of a drug checking program varies greatly depending on the general objective of the program, the cost of equipment, staffing and, most importantly, on the availability of funds. Ideally, a program should provide quantitative and qualitative testing analyses which, in turn, requires advanced drug testing technologies, qualified staff and appropriate infrastructure. In practice, often due to a lack of funds, this approach may not be possible to achieve; thus, interventions are forced to provide limited services, employ less qualified staff and less reliable drug testing techniques.

RATIONALE - illicit drug use in the CEECA region continues to be a public health concern. The prevalence of opioids, new psychoactive substances (NPS) and amphetamine-type stimulants (ATS), including polydrug use (very often NPS combined with other traditional drugs), is observed not only among experienced drug users, but also among young people and other key populations. Drug checking services are not only a harm reduction intervention but also a valuable monitoring mechanism that provides reliable data on the drug market, its changes and developments, supporting policymakers and public health experts to respond to newly emerging needs. The basic principle of drug checking, known also as drug safety testing, or pill testing, is supporting experienced people who use drugs and those who use drugs recreationally to reduce possible harms and prevent overdose by testing illicit drugs to determine their composition (content, purity, potency) and provide the user with harm reduction advice and support. Furthermore, it is an evidence-informed harm reduction tool that helps in monitoring drug market changes by informing policymakers, public health experts, service providers and the general public about the presence of particularly dangerous substances and helping them to adapt policies and interventions to respond to newly emerging trends. Drug checking helps providers to share tailor-made harm reduction information with drug users; to facilitate more informed

decision-making; to form a positive relationship between providers and drug users; it increases the utilization of services; and, to a certain degree, adjusts the "drug market" with the supply chain, matching client expectations. Drug checking services provide realistic data on the evolution of the NPS market, which is collected from drug users, and also facilitates the direct engagement of NPS users with harm reduction programs and other follow-up care services.[6] A drug checking service represents a direct response to the need to reduce the health risks of illegal drug use. For instance, in addition to the benefits of monitoring drug market changes or by reducing overdose, drug checking services provide opportunities - particularly for recreational users who often are not targeted by harm reduction programs - to utilize HIV/Hepatitis testing services, helping service users to know their health status, and be informed about the risk of sharing contaminated drug paraphernalia. High overdose rate underpins the necessity to introduce drug checking services. In response to the overdose crisis, attention is being focused on scaling-up harm reduction programs, including drug checking services which are considered an evidence-based strategy and an instrumental public health response in overdose prevention and a potentially life-saving service.[7]

A global review in 2017 of drug checking services that were operating revealed 31 active drug checking services in 20 countries across the world run by 29 different organizations.[8]

EXPECTED INVESTMENT[9]

- Assessment of the local needs for drug checking services
- Technology/ method of drug checking. The costs of it will depend on what method will be selected. As for the pilot projects, reagent tests are suggested to be purchased. Some examples of tests might be found here: https://www.eztestkits.com/en/ and https://www.protestkit.eu/
- Human resources (Program manager, peer workers, chemists)
- Developing protocol for the drug checking services
- Analysis of pilot drug checking results
- Informational campaigns, dissemination, and development of info leaflets

[6] Giné CV, Vilamala MV, Measham F, et al. (2017). The utility of drug checking services as monitoring tools and more: A response to Pirona et al. Int J Drug Policy. 2017 Jul;45:46-47. doi: 10.1016/j.drugpo.2017.05.018 and, https://energycontrol-international.org/wp-content/uploads/2017/10/Vidal2017_Utility-of-Drug-Checking-services.-Answer-to-Pirona_IJDP.pdf

[7] Wallace, B., van Roode, T., Pagan, F. *et al.* What is needed for implementing drug checking services in the context of the overdose crisis? A qualitative study to explore perspectives of potential service users. *Harm Reduct J* 17, 29 (2020). https://doi.org/10.1186/s12954-020-00373-4

[8] Barratt, M.J., Kowalski, M., Maier, L.J., et al. (2018). Global review of drug checking services operating in 2017. Sydney; National Drug and Alcohol Research Centre, Drug Policy Modelling Program Bulletin No. 24. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Global%20review%20of%20drug%20checking%20services%20operating%20in%202017.pdf.

[9] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

3. OVERDOSE PREVENTION AND PROVISION OF NALOXONE

INTERVENTION AND KEY ACTIVITIES

- Analysis of legal, social and financial barriers to access Naloxone
- Focus group/ needs assessment with people who use drugs
- Increase availability of Naloxone in the ambulance service
- To train police officers how to use naloxone to save life's of people who use drugs.
- Increase availability of naloxone in the harm reduction programs (low-threshold services, needle and syringe programmes, OST programmes)
- Ensure safety of people who use drugs and peers to carry-on naloxone
- Training to peers on how to use naloxone

PRIORITY POPULATIONS - people who use opioids

BARRIERS AND INEQUITIES - in some countries of the EECA region there is no Naloxone at all. In some countries it exists, but only medical personnel can use it (in some countries even ambulance has no Naloxone). In some other countries it is accessible only with doctor's prescription. All this creates a high threshold on people who use drugs, to access a life-saving medication, which is not addictive and can save life. Intranasal naloxone, which is easier to use and not requires any complicated trainings is not available in the region at all.

What is more, criminalization and discrimination of people who use drugs is another inequity, which is demotivating people who use drugs to carry on with them Naloxone. People who use drugs have a fear of being stopped and searched by police, which might interpret Naloxone as a drug, instead of medication.

RATIONALE - deaths associated with drug use continue to increase. Burden of Disease Study estimated that there were 494,000 drug-related deaths in 2019. The latest time series indicates an overall increase in total deaths attributed to drugs of 17.5 per cent between 2009 and 2019. Opioids remain the leading cause of death in fatal overdoses.[10]

With appropriate intervention many opioid overdose deaths may be preventable. Naloxone is a life-saving overdose reversal drug that rapidly counteracts the effects of opioids. It has been used in emergency medicine in hospitals and by ambulance personnel since the 1970s to reverse the respiratory depression caused by opioid overdose, and it is included in the World Health Organization's list of essential medicines[11].

Naloxone has no potential for abuse. It can be injected in the muscle, vein or under the skin or sprayed into the nose. Naloxone that is injected comes in a lower concentration (0.4mg/1mL)

[10] https://www.unodc.org/res/wdr2022/MS/WDR22_Booklet_2.pdf
[11] https://www.emcdda.europa.eu/system/files/publications/2089/TDXD15020ENN.pdf

than Naloxone that is sprayed up the nose (2mg/2mL). It is a temporary medication that wears off in 20-90 minutes. The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect. When given to individuals who are not opioid intoxicated or opioid dependent, naloxone produces no clinical effects, even at high doses. Moreover, although rapid opioid withdrawal in opioid-tolerant individuals may be unpleasant, it is not life threatening[12].

As it is stated in the EMCDDA publication, the research shows that, lots of opioid overdoses occur when other people are present. This means that an opportunity for potentially lifesaving action may exist if bystanders can be empowered to act. However, often this does not happen, either because there is a failure to recognize the seriousness of the situation or, for fear of police involvement, emergency services are called late — or not at all[13].

Several countries in Europe and elsewhere have introduced take-home naloxone programmes that combine provision of the antidote with training in overdose prevention and emergency management. In November 2014, the World Health Organization (WHO) released new guidelines[14], recommending that take-home naloxone should be made available to anyone likely to witness an overdose.

It is important to ensure, that all key parties have access to naloxone, including – ambulances, police officers working in the streets, people who use drugs and their families, and peer and outreach workers, who have a direct contact with people who use drugs. A special attention should be given to those, released from prisons, as there is an extraordinarily high rate of drug overdose deaths (mostly involving heroin or other opioids) in the weeks immediately following release from prison.

EXPECTED INVESTMENT[15]

- Human resources
- Preparation of report on Analysis of legal, social and financial barriers to access Naloxone
- Naloxone kits (maybe intranasal naloxone?)
- Trainings for police officers
- Trainings for peers
- Conducting focus groups
- Advocacy activities

[12] https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf
[13] https://www.emcdda.europa.eu/system/files/publications/2089/TDXD15020ENN.pdf
[14] https://apps.who.int/iris/bitstream/handle/10665/137462/9789241548816_eng.pdf
[15] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

4. Community led monitoring of services.

PRIORITY POPULATIONS - All key population groups

RATIONALE - structural inequalities and determinants of health have direct impact on health and HIV outcomes. Key populations, particularly people who use drugs are subject to discrimination, violence, and punitive legal and social environments, each of which contributes to HIV vulnerability. In order to reach the goals, set out in UNAIDS 2023-2026 strategy we need to adapt services to become more user-friendly, increase health system accountability and address structural barriers. Community-led monitoring is instrumental in shaping effective health services, influencing policy changes, achieving universal health coverage and tailored health care. CLM provides key information to fill critical gaps in the decision-making process that leads to evidence-informed action to improve services. Community-led monitoring is an accountability mechanism led and implemented by community-led organizations. Community-led monitoring requires leading and ownership by independent communities/civil society. Well-funded support of community-led organizations can help translate the intimate knowledge, trust and understanding of affected communities into concrete program improvements.

EXPECTED INVESTMENT[16]

- Human resources (CLM coordinator, other administrative stuff)
- development of CLM tool and/or training on existing CLM tool
- staff costs for field workers (interviewers)
- incentives for respondents
- staff costs or consultant fee for data processing and analysis
- budget for local travel and advocacy meetings

Evidence Base:

- Peerology: a guide by and for people who use drugs on how to get involved. Ottawa: Canadian AIDS Society; 2015. http://www.catie.ca/en/resources/peerology-guide-and-people-who-use-drugs-how-getinvolved
- https://www.theglobalfund.org/media/9632/crs_2020-02cbmmeeting_report_en.pdf
- https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf
- https://healthgap.org/wp-content/uploads/2022/09/CLAW-Best-Practices-in-Community-Led-Monitoring-EN.pdf

[16] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

5. Harm reduction services that can be offered in a drop-in center

INTERVENTION AND KEY ACTIVITIES

- harm reduction resources and commodities;
- primary health care (abscess/wound management, other health issues);
- peer education/consultations;
- user-friendly information;
- laundry facilities;
- food;
- comfortable sitting area;
- computer/Internet facilities;
- education and communication materials;
- drug checking;
- counselling and referral to other services;
- counselling and testing for HIV, hepatitis, STIs, TB or referrals;
- mental-health services;
- housing or shelter services emotional support with family crises;
- alternatives for well-being and healthier lifestyles (workshops, trainings);
- legal advice;
- support in getting papers.

PRIORITY POPULATIONS - all key population groups

RATIONALE - the Global AIDS strategy calls on countries to sharply scale up harm reduction to ensure that 90% of people who inject drugs have access to harm reduction services. A drop-in center provides the opportunity to reach the most marginalized groups of people who use drugs and offer services that address the wider physical and social needs of its clients, beyond harm reduction. This is important because these needs often go unaddressed due to structural barriers, criminalization and isolation of people who use drugs which in turn lead to treatment interruptions and dropouts. Drop-in centers help with HIV prevention communication, information and demand creation for people who use drugs, provide a safe space, and ensure community involvement in service delivery. People who use drugs are experts on their service needs and barriers and prefer services that are led by their peers; thus such centers should always be hosted by staff members who inject drugs who are already known to the community.

EXPECTED INVESTMENT[17]

- Rent;
- Utilities;

[17] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

- furniture and other nessesary equipment;
- staff costs for manager;
- outreach worker (male and female);
- social worker (male and female), peer consultant(male and female);
- psycologist (optional), legal consultant (optional);
- medical professional (optional);
- harm reduction commodities;
- food.

Evidence Base:

- https://www.unaids.org/sites/default/files/media_asset/2017_HIV-HCV-programmes-people-who-inject-drugs_en.pdf
- Good practice guide for employing people who use drugs. Hove (UK): International HIV/AIDS Alliance; 2015. http://www.aidsalliance.org/resources/631-good-practice-guide-for-employing-peoplewho-use-drugs 6. Good practice guide: HIV and drug use: community responses to injecting drug use and HIV. Hove (UK): International HIV/AIDS Alliance; 2010. www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_ original.pdf?1405520726 7. Developing HIV/AIDS work with drug users: a guide to participatory assessment and response. Brighton (UK): International HIV/AIDS Alliance; 2003. http://www.aidsalliance.org/resources/311-developing-hivaids-work-with-drug-users
- "Nothing about us without us"– greater meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute; 2008. http://www.aidsalliance.org/resources/310-nothing-about-us-without-us 10. Reaching drug users: a toolkit for outreach services. Hove (UK) International HIV/AIDS Alliance; 2013. http://www.aidsalliance.org/resources/314-reaching-drug-users-a-toolkit-for-outreachworkers
- Peerology: a guide by and for people who use drugs on how to get involved. Ottawa: Canadian AIDS Society; 2015. http://www.catie.ca/en/resources/peerology-guide-and-people-who-use-drugs-how-getinvolved

6. Innovative activities for women who use drugs and/or live with HIV

INTERVENTION AND KEY ACTIVITIES

- Post-violence counseling;
- referral and linkages to post exposure prophylaxis;
- psychosocial support;
- including mental health services and counselling;
- Training of personnel on gender-based violence and counselling;
- Pregnancy testing;
- Contraception/family planning information and services;
- Introduction of WINGS - evidence-based screening, brief intervention, and referral to treatment service tool designed to identify and address intimate-partner and gender-based violence among women at risk;
- Screening for cervical cancer and STIs.

PRIORITY POPULATIONS - women who use drugs and/or living with HIV.

RATIONALE - women who use inject drugs face higher HIV risk, and high levels of violence from intimate partners, from police, or when engaged in sex work. Gender inequalities are a strong driver of the HIV/AIDS, tuberculosis, and malaria epidemics. The government has committed to realizing gender equality and women's empowerment through the adoption of various human rights instruments, including the Convention on the Elimination of All Forms of Discrimination. Despite some positive changes in recent years concerning gender equality and human rights, many women who use drugs are still subjected to discrimination, criminalization, and structural and intimate violence, have little or no access to gender-sensitive drug dependence or harm reduction services. Women who use drugs are especially vulnerable to gender-based violence from intimate partners and law enforcement personnel and have limited options for support. Existing shelters for GBV survivors are not welcoming to women who use drugs and harm reduction services are not equipped to work with GBV. To reach Global AIDS strategy goal and to have less than 10% of women who use drugs or living with HIV experience gender inequality/violence by 2025 we need to include sexual and reproductive health services, including STIs, hepatitis, post violence care for PUD.

EXPECTED INVESTMENT[18]

- Staff costs for female outreach/social worker;
- consultant fee to conduct training for the emploees on GBV and counselling of GBV survivors;
- procurement of pregnancy tests;

[18] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

- staff costs for part-time on-site OBGYN or budget for external consultations and servical cancer screening;
- staff costs or budget for psycological support;
- costs for supervision of employees working with GBV.

EVIDENCE BASE:

- https://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf
- https://rm.coe.int/improving-the-management-of-violence-experienced-by-women-who-use-psyc/168075bf22
- https://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Women-who-use-drugs.pdf
- https://www.emerald.com/insight/content/doi/10.1108/978-1-83982-882-920200011/full/html
- https://sig.columbia.edu/news/wings-adapted-globally-reduce-violence-against-women

7. Online Harm Reduction Program Services

PRIORITY POPULATIONS - People who use drugs, including young people who use drugs and recreational drug users, as well as other populations, keeping in mind intersectionality.

RATIONALE - People who inject or otherwise use drugs are 29 times more likely to contract HIV than the general population. UNAIDS estimates that in 2019, this group accounted for one in ten new infections. Most people who inject drugs are concentrated in Eastern Europe, East and Southeast Asia, and Southwest Asia.

The risk of HIV and hepatitis C transmission among people who inject drugs can be reduced through harm reduction measures such as needle and syringe programs, opioid substitution therapy, and HIV testing and treatment services. Therefore, increasing access to these services is essential to reduce the spread of these diseases among people who inject drugs.

Over the past decade, the drug market has diversified. In addition to traditional plant-based drugs such as cannabis, cocaine, and heroin, there has been a growth in synthetic drugs. Hundreds of new psychoactive substances (NPS) have been synthesized in recent years, including psychostimulants.

Six Eurasian countries- Belarus, Moldova, Serbia, Kazakhstan, Kyrgyzstan, and Georgia- have seen increased use of primarily psychostimulant NPS, according to a study by the Eurasian Harm Reduction Association. Similar findings were obtained from an assessment by the UNODC Eastern Europe Program Office in Ukraine and Moldova.

The use of the Darknet to purchase and sell drugs is increasing. The sale of drugs on Darknet markets appeared only about ten years ago. However, today the annual turnover of the largest of them, according to the most conservative estimates, amounts to 315 million U.S. dollars. Although this is a small proportion of the total drug turnover, the upward trend is evident: between 2013 and 2016, the number of drug sellers on the Darknet more than quadrupled.

The infiltration of the drug trade into social media and popular e-commerce sites suggests that drug availability is on the rise. The rapid pace of technological innovation, coupled with the flexibility and adaptability of drug traffickers using new platforms to trade drugs and other substances, could lead to a global marketplace in which more drugs are available in more regions, especially given the ability of traffickers to adapt their marketing channels to changing conditions quickly. This, in turn, will accelerate a paradigm shift in drug use.

The acquisition and marketing of NPS in Eastern Europe and Central Asia are made primarily through websites (including Darknet marketplaces), social networks such as VKontakte,

Odnoklassniki, and Facebook, and various messengers such as Telegram, Viber, and WhatsApp. In addition, people who use drugs use the above-mentioned online platforms to communicate with each other, including on issues related to maintaining health while using drugs. This allows service providers to conduct outreach and implement harm reduction interventions online.

It should also be noted that innovations in drug prevention and care have been spurred by the COVID-19 pandemic that began in 2020. As a result, many tasks that previously required personal contact for help can now be done online, by phone, or by mail. In some countries, the rapid pace of innovation has fundamentally changed the delivery of health services for people who use drugs.

These changes dictate the need for online approaches to harm reduction services. It is important to support and develop distant forms of harm reduction: transferring counseling and information online, enabling delivery of necessary handouts or getting syringes, condoms, tests, and masks from vending machines, sending materials by mail, etc.

INTERVENTION AND KEY ACTIVITIES

Web outreach is searching and establishing contacts, consulting, engaging, and retaining people at risk in HIV assistance programs through websites, social networks, messengers, specialized forums, and online platforms in places of the virtual pastime of the target audience. Allows reaching new segments of key groups that would have only been reached with web outreach. Variant 1: passive placing of information: in particular, banner ads on dating sites with information about the creation of separate tops in forums, bots-informers (programs informing users about specific events, for example, about the schedule of test-mobiles in the city) in Telegram. The client initiates the communication. The advantage of the passive approach is its greater acceptability from the user; the communication starts with the interested person, and his information need is satisfied. On the other hand, this approach requires constant resources for promotion and dictates the need to be constantly in touch because the user needs a qualified answer here and now. Option 2: Active mailing of information (e.g., where and how to get tested for HIV, how to order a safe box) to platform users. The advantage is comprehensive coverage for users, who, without it, would probably never think about the problem of HIV. There are risks of being blocked for spam and non-compliance with the platform's terms of use.	Human resources: - Outreach workers with online counseling skills - Counselors (e.g., surgeon, narcologist, lawyer, psychologist) to answer questions outside the competence of the outreach worker. - Handouts (e.g., rapid test, prevention package, etc.). Infrastructure: - smartphone/tablet, - Uninterrupted Internet access, - VPN or Tor browser for working in the Darknet.
A **chatbot** is a program that corresponds with the client and imitates the behavior of a consultant. The simplest bots can collect basic client needs/complaints, make an appointment, perform	Personnel: - an IT specialist for creating and maintaining the program, - experts on bot filling,

initial triage, and switch, depending on the client's request, to the right specialist. Suitable as a screening tool for determining the need for testing and materials, it allows you to automate collecting basic information about the client and the reasons for his treatment, and it relieves staff from routine work. The consultant gets involved in complex, non-standard situations. For example, the bot can tell about the risks of HIV and STI infection, conduct initial screening for the presence of such risks in the client and redirect for testing services (make an appointment for an in-person test or register an order for an oral test by mail), and later provide support for self-testing. "Smart" chatbot can help provide first aid, such as overdoses, to give an algorithm for further seeking medical attention.	- consultants. Infrastructure: - Uninterrupted Internet, - PCs, smartphones - VPN and Tor browser to work in Darknet - Money for a year's subscription to a platform (e.g., Telegram) where the bot will be.
Online/Distance Counseling - Provides information and psychological and professional subspecialty assistance at a distance through electronic communication (Internet, telephone). Providing information and counseling can include training, harm reduction counseling, and referrals to reliable information and other resources, including testing and treatment sites. Health messages are mostly sent to individuals (through personal profiles on websites or dating apps) and sometimes to groups (e.g., chat rooms or Internet bulletin boards). For projects with limited resources (budget, time, and trained staff or volunteers), advertising can be more cost-effective than online outreach provided by paid staff. Option 1: real-time communication - the consultant and client are simultaneously on a phone line or network, communicating via online messengers (Zoom, Skype, Telegram, WhatsApp, Viber, etc.) via video or audio. Option 2: asynchronous communication - through forums, blogs, social networks, communication programs, email, and saving information.	Human resources: - consultants in the areas of counseling - an administrator to distribute incoming calls and online appointments, - an analyst for the analysis of the statistics of appeals, - quality control specialist. - supervisor Infrastructure: - smartphones, PCs, - high-speed Internet and telephone connection, - online platforms for counseling (e.g., a paid Zoom account), - Develop a chatbot for automated recording and distribution of requests or an online pre-registration form (if a counseling service is offered - equipped remote workstations for consultants.

Other online services

- **Mobile or web-based applications** are tools that can provide real-time information to people from relevant groups and help them track their habitual behaviors that increase risk in the context of HIV transmission, overdose, ARV adherence disorder, etc. Such intervention tools can be precious when used on smartphones, as they are widely applicable for communication and finding information on the Internet. Additional features of harm reduction-based apps include information on social services available to individuals or portable electronic devices (e.g., smart watches) that detect the lack of movement associated with overdose.
- **User-led forums and groups** are venues for extensive collaboration, knowledge sharing, and social support regarding HIV prevention and care services for key populations affected by HIV

infection. Exploring these venues can contribute value to research changes in client information searches. Although partnership initiatives are successful in terms of user empowerment, there is a risk that visitors to such Web sites will view information from their peers, often inaccurate and subjective, as more reliable than advice from medical professionals. Knowing exactly what kind of information clients are interested in, it is possible to increase the emphasis on working through these issues during online counseling.

- **Self-testing for HIV online**. Home HIV tests are a convenient way to get tested for HIV in a private place. Home HIV testing is a form of HIV screening that requires additional follow-up if preliminary results are positive. Home HIV tests can be found online, at the pharmacy, health care facilities, and community organizations.
- **Organizing delivery of supplies** - done to support the provision of HIV services for key populations remotely, including ensuring adequate supplies through vending machines or postal and courier services of needles, syringes, condoms, medications, and (during a pandemic) face masks, disinfectants, etc.

EXPECTED INVESTMENT[19]

- Staff costs for female outreach/social worker;
- consultant fee to conduct training for the emploees on GBV and counselling of GBV survivors;
- procurement of pregnancy tests;
- staff costs for part-time on-site OBGYN or budget for external consultations and servical cancer screening;
- staff costs or budget for psycological support;
- costs for supervision of employees working with GBV.

EVIDENCE BASE:

- EHRA (2022) Recommendations for creating online harm reduction services. https://ehra-uploads.s3.eu-central-1.amazonaws.com/5c08f4fc-6521-4130-a559-7837cef982bc.pdf
- HRI. Global Status Report on Harm Reduction, 2022. https://hri.global/wp-content/uploads/2022/11/HRI_GSHR-2022_Full-Report_Final-1.pdf
- UNODC. Coronavirus epidemic (COVID-19) brief review of the impact on drug use and drug services and harm reduction programs in Central Asia, 2020. https://www.unodc.org/documents/centralasia//2020/August/3.08/COVID-19_impact_on_drug_use_in_Central_Asia_ru.pdf
- Eurasian Harm Reduction Association. Harm Reduction Programs in the COVID-19 Crisis Situation in Central, Eastern Europe and Central Asia, 2020. https://harmreductioneurasia.org/wp-content/uploads/2020/05/regional-review_-FINAL_RUS.pdf
- ECOM (2020). Help Online: Best Practice in the Delivery of Digital and Remote Health and Social Services for HIV. Available at: https://ecom.ngo/library/online-care_best-practices
- ECOM (2021). Online Help: Mapping digital and remote HIV-related health and social services for key populations in the EECA region. Available at: https://ecom.ngo/library/online-care_rus
- Web outreach in the context of harm reduction among people who use NPS. Available at: https://harmreductioneurasia.org/wp-content/uploads/2021/05/Веб-аутрич-в-контексте-снижения-вреда-среди-потребителей-НПВ_Alexey-Lahov.pdf

[19] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

- UNP UNITED NATIONS (2021). Recommendations for Web Outreach for People Who Use Drugs. https://www.unodc.org/res/hiv-aids/new/publications_drugs_html/RecommendOutreachRU.pdf
- UNODC. Online Emoji Workshop: online communication of people who use drugs 2020. https://www.unodc.org/unodc/en/hiv-aids/new/stories/emoji-workshop--online-communication-among-people-who-use-drugs.html
- Drugstore anonymous chat counseling. https://drugstore.org.ua/consultants
- Youth LEAD, Youth RISE, Y+. Harm reduction services for young people who inject drugs; 2021. https://youthrise.org/wp-content/uploads/2021/06/FOR-WEB_YL_FINAL-CASE-STUDIES-REPORT_2021.pdf
- NPS Use in Eastern Europe and Central Asia: Regional Report, 2021. https://harmreductioneurasia.org/ru/harm-reduction/new-psychoactive-substances/nps-ee-and-ca.
- https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-020-00448-2
- [1] https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/NPS/NPS_Ukraine_Russian.pdf
- [1] https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/NPS/NPS_Moldova_Russian.pdf
- [1] https://www.unodc.org/documents/centralasia//2020/August/3.08/COVID-19_impact_on_drug_use_in_Central_Asia_ru.pdf

8. Matrix of Essential Interventions according to the Global Fund Modulator

Module	Intervention	Modular Framework [20] page
RSSH		
RSSH: Resilient and Sustainable Systems for Health	**RSSH: Health Sector Planning and Governance for Integrated People centered Services** This includes activities to support national health sector strategy, policy and strategic plans, private sector engagement at the national and subnational level and the development of stronger linkages between health sector and disease specific plans and policy making.	p.10
	RSSH: Community Systems Strengthening Activities to bolster community systems strengthening, such as community-led monitoring, research and advocacy, coordination and capacity building, are strongly encouraged and should be included in the "Community Systems Strengthening" module.	p.13
	RSSH: Health Financing Systems It includes development and implementation of health financing strategies and plans, public financial management reforms, social contracting, blended finance, advocacy for domestic resource mobilization, health financing analytics and resource tracking.	p.17
	RSSH: Monitoring and Evaluation (M&E) Systems This module includes both the cross-cutting as well as disease specific M&E activities such as: (1) Supporting routine reporting systems, civil registration and vital statistics systems, data quality assessments, or population-based surveys; and (2) Strengthening disease-specific monitoring and evaluation systems (e.g., malaria surveillance, HIV patient tracking, TB prevalence surveys).	p.44
HIV		
HIV Prevention: Prevention Package for People Who Use Drugs (PUD) (injecting and	Needle and syringe programs for PWID	p.73
	Opioid substitution therapy and other medically assisted drug dependence treatment for PWID	p.73
	Overdose prevention and management for PWID	p.73
	HIV prevention communication, information and demand creation for PUD	p.74

[20] https://www.theglobalfund.org/media/4309/fundingmodel_modularframework_handbook_en.pdf

9. Mental health care services

INTERVENTION AND KEY ACTIVITIES

Mental health interventions for key populations are the components of the esencial pachageof services for key populations. Essential for broader health: health interventions. Mental health [21]:

Routine screening and management for mental health issues (particularly depression and psychosocial stress) should be provided for people from key populations in keeping with the principles of consent, confidentiality and evidence-based quality. Specific mental health issues and recommendations and a practical guide on addressing mental health issues in non-specialized health settings is provided by the mental health gap action programme (MhGAP)[22], [23]

To ensure proper access of key populations and specifically people using drugs to all complexity of mental health care, starting with psychological support, mental health diagnostic, treatment and care we need to devide interventions on two parts:

1. Interventions to be implemented as component of harm resuction services:

- provision of individual psychological councelling to people using drugs on different issues connected to personal, socila and sexual life, relations with family, employment etc;

- crises councelling and councelling on crises coping approcahes for clients victims of violence or in the threat to life;

- provision of on-line, web-based individual counselling by psychologists;

- organising psychological group trainings on gaining social abnd health skills;

- organising and facilitating self-suport groups meeting by different subgroups of people using drugs (women, young people, aged etc);

- Referral to trained in provision of mental health care for people using drugs and “friendly” psychiatrist;

- organizing on-line outreach[24], psychotherapy or online medical advice by psychiatrist for different groups of people who use drugs. Specifical support needs to be provided to people using new psychoactive substances[25].

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[21] Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations, WHO, 2022, P. 41 https://www.who.int/publications/i/item/9789240052390

[22] mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0., WHO, 2016 https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre

[23] mhGAP Intervention Guide - Version 2.0 for mental, neurological and substance use disorders in non-specialized health settings, WHO, 2019 (available in English, Russian and Ukrainian). https://www.who.int/publications/i/item/9789241549790

[24] Recommendations «Web – outreach for people who use drugs», UNODC, 2021, https://www.unodc.org/res/hiv-aids/new/publications_drugs_html/RecommendOutreachENG.pdf

[25] More about problems in countries https://harmreductioneurasia.org/harm-reduction/new-psychoactive-substances

- Providing mental health medication for free or partial compensation of expenses for medication if the need is exceptional and no other medical insurance is available;

- Professional supervision and post-graduate training for psychologists, social workers and outreach workers by professional psychologists as an obvious component of any of the above-mentioned interventions[26];

- Sharing Information and raising awareness of people using drugs and members of their families on the available health services. Provide comprehensive information on existing services that deal with various mental health and substance use-related disorders. Post information sheets at harm reduction and other service providers, as well as at primary health care institutions and online. On the accessibility level –there is a need for developing information sheets with a description of the activities and contact details of the health, social care, and other facilities in the area (city, county, municipalities) which would make it easier for patients to find and access these facilities and for healthcare providers to direct patients to the most appropriate facilities for their stage of illness.

2. Interventions to ensure integration of mental health services to harm reduction continuum of services

- Establishing partnering with mental health care provision on the local level to ensure referral from harm reduction sites;
- Train primary health care workers basic skills to conduct mental health tasks such as screening and treatment of anxiety and depression in primary healthcare and to create a stigma-free cultural space, including increasing awareness of mental health protective and risk factors and danger signs among primary care professionals to enhance early detection and reduce stigma.
- To organize community-led monitoring of access to and quality of the mental health care services for people using drugs with following building cooperation to improve situation.
- Develop multidisciplinary teams that work predominantly in the community context and in the natural environment of clients as outreach teams;
- Introduce and develop crisis outreach teams with a psychiatrist or psychiatric nurse available
- Integrate social and health services, including the involvement of addictologists in mental health centers
- Information campaigns aimed at social inclusion, prevention of mental disorders, and diminishing stigma of mental health problems among health and social care workers, people using drugs and their families;
- Improvements in educational curricula for mental health specialists in addictology and provision of mental health care to people who use drugs. Promote best practices developed by addictologists, psychologists and mental health specialists in relevant professional communities at national and international levels. Add new subjects or increase the hours of subjects in psychotherapy, psychology, addictology and harm reduction for future doctors (especially psychiatrists) and social workers.

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[26] Методический комплекс «Внедрение и функционирование системы супервизионной поддержки»: Книга 1. Алгоритм внедрения и функционирования системы супервизионной поддержки. — К: МБФ «Альянс общественного здоровья», 2018. https://aph.org.ua/wp-content/uploads/2016/07/supervisor-book-1.pdf
Книга 2. Методические рекомендации по проведению супервизии для сотрудников НПО (по результатам работы проекта «Усиление потенциала с целью внедрения качественных гендерно-чувствительных интервенций снижения вреда в Украине»). — К: МБФ «Альянс общественного здоровья», 2018. https://aph.org.ua/wp-content/uploads/2016/07/supervisor-book-2.pdf

PRIORITY POPULATIONS - people who use drugs, new psychoactive substance and stimulants users, people who use drugs survived violence or threat to their lives.

RATIONALE - The co-occurrence of substance use disorders with other mental health conditions (dual disorders) is very common, and these patients typically have more severe problems – clinically and psychosocially – than patients with only substance use disorders.

The most frequent psychiatric comorbidities among individuals with substance use disorders are depression, anxiety, post-traumatic stress and personality disorders (mainly antisocial and borderline). The presence of these comorbid mental health problems increases emergency and psychiatric admissions, as well as the likelihood of relapse into drug use and premature death, and, overall, leads to poorer prognoses for both the psychiatric and the substance use disorders27.

BARRIERS AND INEQUITIES

Living a healthy and positive life is not possible without adequate mental health; mental health problems may have a significant impact on daily life and its quality without being treated effectively.

People who use drugs, like all people, should have an appropriate access to mental health support. Mental health issues and drug dependency can be brought in by the same factors, like poverty, lack of access to healthcare and other services, homelessness, stigma and discrimination; people may also start or continue using drugs to deal with mental health issues. Providing adequate access to mental health services for people who use drugs "without framing drug use and/or dependence as mental health issues in absolute terms" should be considered a priority. People who use drugs should be able to exercise their right to have a choice regarding their physical/mental health and relevant ways to encourage better access to mental health or barriers hampering such access.

For the past several years certain factors have influenced the optimal access to mental health services:

- influence of COVID-19 pandemic on mental health issues was obvious due to increased stress situations, lockdowns and growing waves of home and gender-based violence as well as extra strain on health care systems all over the world.
- the most recent war of Russia against Ukraine caused nearly one third of its population (over 14 million) to flee the violence and abandon their homes in search of safe haven inside the country or abroad, with over 6 million Ukrainians having crossed the borders and living as refugees abroad, while over 8 million are internally displaced within the country. Many of these people are or will be in the nearest future in dire need of essential mental health support, also to mention the more specialized services needed for key populations, including people who use drugs, OST clients and NPS users including war refugees from Ukraine.

The mental health system existing in EECA countries in most of the cases is not capable to address needs of people who use drugs due to following system issues:

- Emphasis on large mental institutions
- Hospitalization as the principal form of psychiatric care. Mental health care remains largely institutionalized with little alternative care options in the community. The priority is given to support large mental hospitals and a high number of psychiatric beds.
- Biological treatment methods predominate in comparison with psychotherapy.
- Improper and uneven allocation of resources
- Lack of client-centered approach.

[27] EMCDDA paper "Co-morbid substance use and mental disorders in Europe: a review of the data", 2015 https://www.emcdda.europa.eu/system/files/publications/822/TDAU13002ENN_457231.pdf

Some specific mental health challenges are encountered by a more specific group of people using NPS (new psychoactive substances). Services for NPS users are usually not available in existing harm reduction packages of services (syringe exchange, distribution of condoms and disinfectants, overdose prevention, testing for HIV and other infections, psycho-social assistance, etc.) and, therefore, opportunities to receive help with mental health or behavioral disorders due to the use of NPS is limited. Only a few countries in the region have established clinical protocols for the diagnosis and treatment of mental health and behavioral disorders by the use of NPS and even those are not widely used due to lack of knowledge among health professionals, resulting in lack of adequate medical assistance for NPS users. To list key barriers for people using drugs to access mental health care facilities are following[28]:

- Stigmatisation/discrimination in health institutions and judgmental attitudes toward people who use drugs from the general public, still remain a barrier for those who may be in need of mental health services.
- Lack of mental health - substance use treatment service integration, service coordination and multidisciplinary referrals
- It is also very difficult for people in the OST program to access treatment in a psychiatric ward, for example, if their condition requires stabilization in a mental health area other than an addiction (i.e., depression, psychosis, etc.). Even wards specifically designed to treat dual diagnoses have difficulty with opioid agonist administration.
- Lack of mental health professionals, there is a high overload of work and thus psychiatrists and/or psychologists tend to refer the patients that they consider as “not our clients” to the narcologists
- Lack of Understanding substance use and addiction among mental health professionals
- Lack of knowledge about the available help among people who use drugs
- Misconceptions regarding psychiatry and medication among people who use drugs

EXPECTED INVESTMENT[29]

- Human resources (such as psychologists, mentor/ supervisor for psychologists, part time psychiatrist, experts to develop information campaigns, experts to develop education curriculum and training modules for mental health care providers);
- Regular trainigns and supervision sessions for specialists;
- Necessary infrastructure (such as computers, tablets, or smartphones; uninterrupted and secure internet access; membership fees for certain platforms; and VPN and TOR browser if you plan to conduct web outreach on the darknet) for ;
- Development of relevant, engaging, and culturally competent content (preparation of information, design of leaflets, videos, etc.)

[28] Based on the recent EHRA assessment on Optimal access to mental health care services for key populations in emergency situations related to COVID-19 and war crisis (unpublished report)

[29] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

10. Strengthening access to justice and legal information for people who use drugs in accessing the right to health

INTERVENTION AND KEY ACTIVITIES

The overall goal of this area is to improve the effectiveness of the HIV continuum of care by overcoming legal barriers for representatives of the community of people who use drugs.

- To build the capacity of paralegals to eliminate legal barriers to access to HIV continuum of care for people who use drugs.
- Provide paralegal assistance to community representatives of people who use drugs to overcome legal barriers to accessing continuous HIV care.
- To address systemic legal barriers to reduce stigma, discrimination, and criminalization and, ultimately, to reduce the vulnerability of the community of people who use drugs to HIV and improve their access to health and social services.
- Creation of a database with reports on violations of the rights of people who use drugs, which relevant specialists will compile; the database will allow to identify and analyze trends and problems in the field of human rights and develop effective strategies to protect the rights of relevant beneficiaries.
- Developing and maintaining tools for collecting information on human rights violations and providing paralegal and professional legal assistance. Creation of a database with reports on human rights violations, which relevant specialists will compile. The database will allow to identify and analyze trends and problems in the field of human rights and develop effective strategies for protecting the rights of relevant beneficiaries.
- Legal expert support for the work of paralegals.
- Involvement of the public, partners, and the media in advocating for the resolution of identified systematic violations; dissemination and coverage of strategic and systemic cases of violations of beneficiaries' rights in the media.

PRIORITY POPULATIONS - people who use drugs, new psychoactive substance and stimulants users, people who use drugs survived violence or threat to their lives.

RATIONALE - Due to stigma, repressive, discriminatory, criminalizing legislation, and the practice of their application, the most vulnerable key populations - people who use drugs, sex workers, MSM - avoid getting into the view of health services and often fall into the view of law enforcement agencies, where instead of help and referral to medical services they receive punishment and arrests. Therefore, if we focus exclusively on the community of people who use drugs, then, unfortunately, all HIV prevention services (harm reduction and treatment services) provided by the standards have limited effectiveness and scalability due to the significant practice of violations by law enforcement agencies.

The advantage of paralegal assistance over professional legal assistance is mainly concentrated in the fact that paralegals know the community they work with and the community's needs better than lawyers, attorneys, and other legal professionals. In most cases, beneficiaries trust them. In

addition, by using a variety of tools and strategies, paralegals can often solve legal problems faster than the formal legal system.

The resource of the paralegal network will help to improve and expand the activities of mediation and case support for beneficiaries, increase the number of cases of community representatives seeking help and protection, and increase the visibility of legal needs for the human rights community.

Additionally, it should be noted that paralegal services can be a significant help in advocating for removing legal barriers faced by beneficiaries. After all, in many cases, paralegals can document and analyze the information received on documented violations of beneficiaries' rights, thus creating an evidence base for further regulatory changes.

Clients' experience helps identify priorities for legal and policy reform at the regional and national levels. Supporting a national network of PWID paralegals is crucial and provides evidence for PWID rights campaigns.

EXPECTED INVESTMENT[30]

- Human resources
- Regular trainigns and supervision sessions for specialists;
- Necessary infrastructure;
- Development of relevant, engaging, and culturally competent content

SUGGESTED INDICATORS

- Number of supporting paralegals who were trained trained and qualified to provide peer-to-peer paralegal support
- Number of cases of human rights violations and legal barriers documented;
- Number of analysis of trends in human rights violations for specific communities conducted
- Number of cities (or other territorial units) where peer-to-peer paralegal support is provided
- Number of beneficiaries for whom peer-to-peer paralegal support is available
- Number of beneficiaries who received paralegal assistance and whose legal barriers were resolved as a result of the paralegal support provided
-

EVIDENCE BASE:

- Technical Brief: Harm Reduction for People Who Use Drugs: Priorities for Investment and Increased Impact in HIV Programming https://www.theglobalfund.org/media/1279/core_harmreduction_infonote_en.pdf.
- Technical Brief: Prisons and Other Closed Settings: Priorities for Investment and Increased Impact https://www.theglobalfund.org/media/12471/core_prisons-other-closed-settings_technicalbrief_en.pdf
- Technical Brief: Community Systems Strengthening (CSS) https://www.theglobalfund.org/media/4790/core_communitysystems_technicalbrief_en.pdf
- Technical Brief: Removing Human Rights-related Barriers to HIV Services https://www.theglobalfund.org/media/12445/core_removing-barriers-to-hiv-services_technicalbrief_en.pdf
- Introducing comprehensive HIV and Hepatitis C programs for people who inject drugs https://inpud.net/wp-content/uploads/2022/01/IDUIT_RU_new_Final.pdf

[30] For more information, use the costing tool - https://www.dropbox.com/sh/z90xqm7hjal4gzl/AACILqr20E7BtKPo7Vn2hExfa/Russian?dl=0&subfolder_nav_tracking=1

- HANDBOOK ON Ensuring Quality of Legal Aid Services in Criminal Justice Processes https://www.unodc.org/documents/justice-and-prison-reform/HB_Ensuring_Quality_Legal_Aid_Services.pdf
- A Meta-Narrative Literature Synthesis and Framework to Guide Future Evaluation of Legal Empowerment Interventions https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6293352/
- Best Practices in Reaching 'Hidden' Populations and Harm Reduction Service Provision https://www.emerald.com/insight/content/doi/10.1108/978-1-83982-882-920200030/full/html#ch25-lev1-6.
- Key Programmes to reduce strigma and discrimination and increase access to justice in national HIV responses. Guidance note. UNAIDS, https://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf
- Know Your Rights, Use Your Laws. Handbook. UNDP. https://www.undp.org/eurasia/publications/know-your-rights-use-your-laws
- Improving outcomes along the HIV cascade for people who inject drugs. HIV Legal Network. 2020. Online: https://www.hivlegalnetwork.ca/site/human-rights-and-support-in-health-care-improving-outcomes-along-the-hiv-cascade-for-people-who-inject-drugs/?lang=en