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Values and preferences of key populations: consolidated report

This report was prepared to inform the World Health Organization Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations development process.

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Mary Henderson (WHO consultant), provided the consolidated analysis of values and preferences and this final report. **Alice Armstrong** (WHO consultant) supported Mary Henderson and contributed through the consolidation and analysis of the young key population components of the consolidated report. Alice Armstrong also coordinated the collection of young key population values and preferences processes performed by numerous youth and community organisations as part of the development of the HIV and young key population technical brief series and included within this report (see listed below and Annex 6).

The individuals, community networks and organizations that carried out the values and preferences work are listed in table 1 within the methods section. Reference to their work is also listed below:

- **Caitlin Kennedy & Virginia Fonner.** Pre-exposure prophylaxis for men who have sex with men: a systematic review ***(see Annex 1)*** & Pre-exposure prophylaxis for people who inject drugs: a systematic review ***(see Annex 2).***
- **The Global Forum on MSM and HIV (MSMGF).** Values & preferences of MSM: the Use of Antiretroviral Therapy as Prevention ***(see Annex 3.1).***
- **Mary Henderson.** Values and preferences of people who inject drugs, and views of experts, activists and service providers: HIV prevention, harm reduction and related issues ***(see Annex 3.2).***
- **Mira Schneider.** Values and preferences of transgender people: a qualitative study ***(see Annex 3.3).***
- **UNAIDS.** Sex workers' hopes and fears for HIV pre-exposure prophylaxis: recommendations from a consultation meeting. Forthcoming 2014.
- **AVAC & GNP+.** What do key populations in South Africa think about PrEP and TasP? Understanding the needs of key populations in the context of using ARVs for prevention. Forthcoming 2014.
- **Youth Research Information Support Education (Youth RISE) and Joint United Nations Programme on HIV/AIDS**. Experiences of young people who inject drugs and their challenges in accessing harm reduction services. Forthcoming 2014.
- **Youth Voices Count.** Policy brief on self-stigma among young men who have sex with men and young transgender women and the linkages with HIV in Asia. Bangkok: Youth Voices Count; 2013.
- **HIV Young Leaders Fund.** "First, do no harm:" an advocacy brief on sexual and reproductive health needs and access to health services for adolescents 10–17 engaged in selling sex in the Asia Pacific. New York (NY): HIV Young Leaders Fund; forthcoming 2014.
- **Youth Leadership, Education, Advocacy and Development Project.** Access to Youth Friendly HIV services for Young Key Affected People (YKAP) in Asia. unpublished data.
- **United Nations Population Fund**. Community consultations with young key populations, unpublished data.

Sincere thanks go out to all those involved in the consultations.

1. Background

WHO is consolidating existing guidance for key populations and including important new recommendations to address issues for which new evidence or experience have become available. The consolidated guidance will consider a range of elements that are common across all key populations as well as highlighting specific issues that are unique to individual population groups. It will guide and support countries to plan, develop and monitor acceptable and appropriate programmes that include a range of issues that affect members of key populations and their ability to access HIV prevention, treatment and care, and harm reduction services.

Key populations covered by this work include men who have sex with men (MSM), transgender people (TG), people who inject drugs (PWID), sex workers (SW), prisoners, migrants and adolescent and young people from key population groups (YKP).

An essential element of this work has been engaging and partnering with key population groups and networks to understand their values and preferences related to HIV and harm reduction service provision, to learn from their experiences and to incorporate their suggestions for building on existing effective programming. A number of global and regional processes explored the values and preferences of different key populations around different themes. This summary report highlights key messages that are common across all, or a number of, key population groups and notes other specific issues that are of particular concern to individual groups.

The results of this consolidation are presented in tables organized into five main topics:

- **Cross-cutting issues** (includes human rights, protection, criminalization, vulnerability, service delivery issues, social and interpersonal issues, access to services)
- **HIV prevention** (includes HTC, commodities, services and information)
- **Testing modalities** (includes consideration of access, clinic-based vs mobile and outreach services, and self- testing)
- **ART** (includes treatment and care services, ART for prevention)
- **Harm reduction** (includes the comprehensive package and related issues)

2. Methods

This consolidation comprises findings from 13 studies, group consultations, online surveys or literature reviews conducted from 2012–2014. Those are listed with authors in table 1.

Table 1. Contributing individuals, networks and organisations to the values and preferences

KEY POPULATION	AUTHOR (ORGANIZATION OR INDIVIDUAL)	TOPIC(S)
YKP	1. Youth Rise (YPWID)	Comprehensive harm reduction package
	2. HIV Young Leaders Fund (YP who sell sex)	Experiences of young people who sell sex; exploring programmatic approaches and suggestions from YSW
	3. Youth Voice Count (YMSMTG)	Self –stigma, HIV and human rights
	4. UNFPA (YKP)	Access/availability to services and support
	5. Youth LEAD (YKP)	Accessibility of services
MSM (multi-country)	6. MSMGF	HTC, access to services, ART for prevention, discrimination, violence and legal issues
MSM (multi-country)	7. Caitlin Kennedy (JHU)	PrEP (part of systematic review)
PWID (Ukraine)	8. Caitlin Kennedy	PrEP (part of systematic review)
PWID (multi-country)	9. Mary Henderson (independent consultant)	HIV prevention, ART for prevention, harm reduction, community distribution of naloxone
PWID (Vietnam)	10. Kristine Buchman and Masaya Kato (WHO, WPRO)	Early ART and periodic HIV testing
SW (South Africa)	11. Wits Reproductive Health Institute	PrEP
KP (South Africa)	12. GNP+ and AVAC	PrEP and TasP
Prisoners	13. Amee Schwitters (CDC)	Condoms, drug dependence treatment, HTC

Data from the reports were entered into a spreadsheet; findings were categorised by key population group; country/region; theme; values, views or experience; and preferences or recommendations. Common values and preferences across groups as well as issues specific to individual groups were identified through qualitative grouping and analysis. Findings reflecting the views of clear majorities of respondents or most of the KP groups are listed as common values and preferences or key messages. However, due to the variations in

themes explored by different studies and reviews, analysis of findings may require further data collection to be conclusive.

3. Summary of key findings

The following tables present the common themes across all or most key population groups, and issues unique to specific groups or regions within each main topic area.

3.1 Cross-cutting issues

Table 2. Values & preferences across key population groups: cross-cutting issues

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
1. Criminalization of key populations and specific practices associated with these communities undermines HIV prevention and harm reduction; threat of harassment, detention is a major barrier to uptake of services; possession of condoms, drug paraphernalia used as 'evidence' of illegal behaviour.	**Legal reforms and protections needed** to reduce fear and to facilitate utilization of services and ensure that HIV prevention, treatment and care, and harm reduction are accessible and effective. ***WHO requested to take a strong position on this issue in partnership with other relevant bodies (UNODC, UNAIDS, and other relevant partners).***	**PWID** considered by many to be the most marginalized of all KP groups; decriminalization necessary to support uptake of services, retention in care and adherence to ART. Criminalization of HIV in some countries contributes to secrecy and leads to targeting of **all KP** and abusive application of laws, entrapment and inappropriate charges (aggravated assault, non-disclosure of HIV status) – ultimately, this fuels the epidemic in these countries.
2. Lack of protection; widespread experience of harassment, financial exploitation and physical and emotional abuse by local police.	Advocacy and legal reforms needed to help change the way that KPs are viewed and treated by law enforcement as well as by society. Accountability/enforcement mechanisms need to be developed and implemented to ensure that individuals' rights are protected. Access to legal services.	In Nepal, **YPWID** can be abducted with parental consent and forced into abusive and long-term 'rehabilitation programmes'. In some Middle East and North Africa (MENA) countries, **PWID** who seek services are reported to the police; bribes are paid to get overdose treatment without reports to police; PWID die of OD when peers fearful of calling for emergency services.
3. Critical enablers not sufficiently in place for KP: • Protection of human rights • Social and economic inclusion (including racism and loss of cultural identity in some settings where certain communities confront extreme social and economic exclusion)	***WHO requested to take a strong position on broader societal issues when engaging with countries at highest levels of government.***	

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
• Poverty, hunger homelessness common across regions • Lack of access to basic health services, including mental health and psychological follow-up • Stigma and discriminatory practices by key duty bearers in society (health system, law enforcement, educators)		
4. Health provider issues: Stigma, discrimination, judgmental attitudes, harassment, vocal hostility, complicity with police, lack of sensitivity, lack of understanding of KP-specific issues. Breaches of confidentiality, with colleagues, with families of patients, with law enforcement.	Training, mentoring and professional support urgently needed for providers serving key populations. Guaranteed confidentiality required to establish trust and to encourage uptake of services. Peer-led services accompanied by peer support are considered the most acceptable and the most effective for all KP groups.	Former or active injecting drug users often barred from providing services; this deprives **PWID** of valuable support and services from people with lived, shared experience. In some countries, training and support are urgently needed at lower levels of the health system where providers have less capacity, professional support and understanding of KP issues; often little knowledge of updated recommendations that may affect KP.
5. General lack of information about human rights, legal services, interventions.	A wide range of communication channels and media (including for low-literacy audiences) should be used to communicate lifesaving and other practical information for KP, including community-specific info.	**YKP** need education on their rights and mechanisms for reporting rights violations. *(Note: Not mentioned in other studies, but likely a common issue across all KP groups.)*
6. Lack of KP-specific services.	All KP feel that services specific to their needs are preferable to services designed for the general public; at the same time, they request that certain services, such as ART, be delivered alongside other health services in order to remove the stigma attached to HIV-related services. Outreach and mobile services preferred.	Services tailored for **YKP** are urgently needed. In general, YKP have a sense of being young and healthy, and they have a different perception of their risks and their needs for services; youth-targeted outreach and mobile services preferred. YKP reluctant to seek services with older members of the KP groups. Need to address the needs of YKP in ways that encourage utilization of services and minimize their exposure to abuse and arrest. **Prisoners** have access to few services; confinement creates contradictions and challenges, e.g. in some places, NSP may be provided, but drug use is illegal and penalized; condoms may be provided but sex is prohibited. Comprehensive HIV prevention and harm reduction services and

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
		commodities should be available in prisons.
7. Vulnerability due to lack of critical enablers in most settings.	Community-based services can help to reach the most vulnerable in society, but action at the government/policy level is also needed. ***WHO requested to take a strong position on broader societal issues when engaging with countries at highest levels of government.***	**YKP** experience more acute, age-related vulnerability due to lack of ID papers, exploitation from 'gatekeepers' and gangs, homelessness/lack of caregivers, blaming and shaming by families and in the education sector, poverty, mental health and lack of educational and employment opportunities. **YMSMTG** experience violence, especially targeting young boys thought to be homosexual. Especially in Eastern Europe & Central Asia (EECA), **PWID** are pushed to the edges of society, not considered as having families and friends, not considered worthy of health services, especially harm reduction. In South Africa, **SW** who are marginalized or who work informally have little representation, creating challenges for advocacy and participation.
8. Social / interpersonal issues: • Stigma and discrimination • Family rejection • Psychological distress • Fear of disclosure	Social mobilization, public information and awareness campaigns to reduce stigma and discrimination against KP. Peer support for practical information, self-esteem, validation of personal choices and identities.	**MSM** feel particularly affected by sexual and HIV-related stigma.

3.2 HIV prevention: HTC, commodities and services

Table 3. Values & preferences across key population groups: HIV prevention

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
1. Access to HTC services limited by: • Criminalization of KP behaviours • Fear of harassment, detention, prosecution • Targeting by police • Lack of protection • Societal fear and intolerance, • Provider attitudes, harassment, coerced testing, lack of confidentiality, understanding, shaming of KP behaviours, poor communication skills • Structural issues, cost, distance, separated services • Individual issues such as HIV and sexual stigma, shame, self-stigmatization • Poor quality of services (waiting times, stigmatizing signage, provider attitudes and skills)	Community-based, mobile and outreach services tailored to specific KP needs. Integration of services; comprehensive services (HIV + other). Safe spaces for all KP. Legal reforms that recognize basic human rights and provide accountability and enforcement mechanisms. Need to make providers more accountable for breaches of confidentiality, harassment and all other unprofessional and discriminatory treatment of patients.	**MSM** feel excluded by homophobia. Age of consent is viewed as a barrier for most **YKP**, although many providers report making decisions about services in the best interest of young clients and waiving consent requirements when necessary. However, this can be risky for providers, and consent laws need to be reviewed where HIV prevention and treatment, sexual and reproductive health and harm reduction are concerned. Free services most important for **YKP.** Access enablers for **YKP** include outreach workers, peer educators, partners, brothels/pimps. In MENA, **YPWID** face juvenile detention if they go for services. In Vietnam, **PWID** required to attend testing with a peer educator in order to avoid fee; considered burdensome and a deterrent to seeking testing. In Nepal, **YPWID** can be abducted with parental consent and forced into abusive and long-term 'rehabilitation programmes'. **YKP** need opportunities to return to school or for skills development and job placement.
2. Availability of services limited by: • Services delivered only in formal health system settings • National priorities	Community-based, mobile and outreach services tailored to specific KP needs are preferred; more flexibility for reaching isolated or marginalized communities	Services for **prisoners** not available in most countries. Limited services for **YKP** in most countries.
3. Information lacking re services and specific interventions.	Need access to info via many channels: a/v, hotlines, SMS technology, peer education. Need literacy programmes and info on 'how to . . . ' safely, info for partners and families.	**YPWID** report lack of info, misinformation, myths re contraception (beyond OC and condoms), emergency contraception and emergency HIV prevention (PEP); abortions common and YPWID often turn to dangerous alternatives such as

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		black market supplies, self-abortions and non-medical OD management. For **MSM**, knowledge about services and resources supports self-esteem, the freeing sense of being 'out', autonomy
4. Condom use important regardless of new interventions but insufficient supply of condoms and lubricants in most settings.	Need to increase supplies (of male and female condoms) in most settings; reduce costs where currently too high (typically in countries where moralistic policies in place).	**SW** report insufficient supply of female condoms and criminalization of possession in some countries **YKP** report no/low condom use and no/low contraceptive use; poor condom negotiation skills. **YSW and YMSM** report incentives for unsafe sex: more money, pressure from clients, pressure from partners, knowledge about improved HIV treatment creates a false sense of security/protection. Especially important for **prisoners** but not widely available.
5. Reasons for testing: • Knowing one's HIV status • Access to related services • Ill health • Coercion • Pregnancy	Increasing uptake of testing is important to reduce late diagnosis and for enrolment in related prevention, treatment and care services as well as for monitoring purposes, but barriers must be addressed and enablers identified and reinforced. Rapid testing key to increasing uptake for most KP.	**YPWID** in one USA setting receive financial incentives for testing; without incentives they would not test as much In SA reasons for testing among all **KP** also include rape and sense of responsibility

3.3 Testing modalities

Values and preferences around different testing modalities were explored only with PWID and young members of the PWID community.

Table 4. Values & preferences across key population groups: HIV testing

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
1. Most PWID reluctant to seek testing unless provided at sites where harm reduction services received; stigma and fear of harassment and prosecution, as with most other health services provided at public facilities.	Rapid testing considered the most acceptable for KP; reduces waiting time as well as costs for transport to take a test and return for results, repeated exposure to judgmental providers and risk of legal consequences. Mobile and outreach services considered the most accessible and acceptable testing modality; assumption of peer support connected with these services Confidentiality is essential – in some settings, women who receive a positive diagnosis are sent out of the home.	PWID in MENA most reluctant to seek testing services as they may be reported to police, or detained. YPWID in one setting in the USA get financial incentives for testing; most would not get a test without the incentive. In Nepal, YPWID risk abduction and forced rehab when they seek any services; need safe spaces and outreach workers to provide testing in this setting. In Vietnam, mobile services for PWID acceptable only in urban areas where some level of anonymity is assured. Late diagnosis a fundamental problem for PWID in Latin America.
2. Very little experience or awareness about self-testing	Most PWID feel this is not a good option due to the lack of counselling, referrals and follow-up; only acceptable where no other options exist and where full information is provided regarding taking the test, understanding the results and the importance of seeking follow-up services for confirmation of results, counselling and follow-up service.	
3. Peer support and peer-led services are key to uptake of testing for PWID.		

3.4 Treatment and care, ART for prevention

The use of antiretrovirals was considered in different studies in the context of treatment and care services, and in the context of prevention, specifically pre-exposure prohylaxis (PrEP), post-exposure prophylaxis (PEP), treatment as prevention (TasP) and early initiation of ART.

Table 5. Values & preferences across key population groups: treatment, care and ART for prevention

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
1. Barriers to treatment and care include: • Provider-related issues – stigma, judgmental attitudes, lack of understanding of KP issues and needs, lack of confidentiality, insensitivity, pressure/coercion to initiate treatment, warnings of death if treatment not initiated • For some KP, criminalization of behaviours is a disincentive to seek services until absolutely necessary, resulting in late diagnosis and poor health outcomes on ART • Registration as a PWID (when starting treatment) can affect job opportunities and freedom to travel, create other sources of discrimination and harassment • Parental consent required for YKP • Distance and cost to services • Irregular and unsustainable NGO services	ART best delivered through KP-specific services, especially for PWID (harm reduction services); where ART only available in hospitals, some KP will not go for services. KP prefer to access ART and related services through outreach services and NGOs; peer support for adherence valued highly Need more info on ART – clarifying individual health benefits, benefits of starting earlier, evidence around relationship between viral load and HIV transmission, info on side effects, the importance of adherence to lifelong treatment and strategies for adherence, addressing myths around ARVs. While ART is often difficult for KP to access as it relies on adherence and retention in services that are often perceived as hostile to KP, most people say that it is a good thing – people feel better, they look better and it gives individuals a sense of taking charge of their lives.	**SW** note the challenges of adherence given the unpredictability of their working life, including travel away from their homes where they access treatment services. **YKP** are particularly excluded, as there are so few services that are set up and staffed to serve the particular needs of young members of key populations – with assurances of safety, confidentiality and comprehensive services. ***Adult KP and YKP consider this an urgent issue.***
2. PrEP: • Possibility of stigmatization (association with HIV) • Concerns about resistance • Lack of information and awareness • Concerns about misuse (selling to others, stealing) • Prisoners, SW and MSM considered most in need	Should be an individual choice based on full information about the implications – adherence to a daily pill regimen, possible resistance, side effects If offered, should be **only in the context of comprehensive services**, not as a substitute for proven interventions.	**SW** views generally favourable; viewed as additional protection, esp in cases of rape; concerns about misunderstandings re preventing STI and pregnancy, funding/sufficient supplies, concern about reducing community cohesion between HIV+ and HIV- people; must be offered alongside other health and treatment services, and need to

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of PrEP due to increased exposure to risk	Significant objections based on the current lack of access to ART for HIV+ PWID and other PLHIV. Significant objections based on concerns that the availability of PrEP will undermine the availability and quality of proven harm reduction interventions.	continue to promote condoms so that HIV prevention not reduced to taking a daily pill. Info needs to be comprehensive and transparent, the importance of continued safe sex practices, side effects, resistance, need for regular testing and the correct use of periodic PrEP. Promotion and delivery need to be community-led. **MSM** have concerns about reducing sexual inhibitions, and side effects and cost; interest linked to perception of not having to use condoms; support declined slightly when provided with more info about implications of PrEP. **PWID** generally not supportive except in countries where harm reduction inadequate (esp in EECA); chaotic lives of most PWID would make adherence and retention in care very challenging; not ethical when millions of people who are HIV+ and currently eligible for ART can't get it; most importantly, no necessary when there is a proven package of harm reduction interventions that can be made available (they are generally low-cost and easy to implement, in contrast to PrEP). Some PWID feel that the discussions about PrEP distract from the real problem facing the community, which is Hep C. In one study of **128 PWID in Ukraine**, majority of participants would take it; numbers decreased slightly when more info about side effects was provided (as with MSM study); injections preferred over daily pills. Highly unfeasible for **YPWID** who are very reluctant to seek services, who have very chaotic lives and who don't generally perceive themselves at risk.
3. PEP (only explored two studies with MSM and PWID)	Clear need to improve awareness and knowledge around PEP.	Most **MSM** noted never having been offered PEP and expressed a high desire to have it made available through gay-friendly CBOs. Most said they would take it if it were available and free or low cost, and if offered in a safe location, such as the CBOs where the consultation took place. They

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		also highlighted the need for strong education campaigns regarding PEP in the context of other prevention strategies. **Lack of Awareness and Knowledge**. Little awareness of the availability of PEP – everyone has a right to know about it, but in most places **PWID** will have difficulties accessing PEP due to provider attitudes toward PWID; PWID will be reluctant to ask for it as it may expose them to prosecution or additional stigma and harassment. Not considered feasible for most PWID who do not have the conditions of life or support to be able to adhere to the treatment for 30 days. Better for **PWID** to have a dependable supply of clean needles and condoms.
4. Early initiation of ART (only explored with PWID, MSM and a group of KP in SA)		**MSM** view early initiation favourably although unsure of feasibility. **KP** in SA feel that that this should be available for all members of KP who are HIV+. Views of **PWID** are mixed: • Unlikely when most PWID who are eligible for ART now are not getting it and late diagnosis is common • PWID are reluctant to go for services in general • Easier ways to reduce transmission in ways that do not place an unnecessary burden on PWID • Intervention is mostly for the public's health – interventions should be concerned with the individual's health • Concerns about resistance • Could be beneficial to some with full information on side effects, adherence etc • Better to start when one is feeling well, adapt to adherence • Must be a fully-informed individual choice

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		It is noted that there is not much information about early initiation of treatment or new recs on ARVS – there need to be better strategies at country level for dissemination of this info at all levels of the health system so that providers as well as the public know all the current options for HIV treatment and prevention. ***This is a health equity issue as well as a basis for advocacy in settings where options are limited and governments are not ensuring access to critical interventions.*** Early treatment can be very beneficial to individuals in countries where HIV is criminalized; if PLHIV are encouraged to begin treatment early, they will achieve viral suppression and be less vulnerable to charges of 'aggravated assault'.
5. TasP (only explored in one study with mixed KP participation):		Concerns about placing burden of protecting others on the shoulders of PLHIV. Can reduce stigma and motivate people to test. Opportunity for more sexual partners and unprotected sex. Good for society as well as the individual. Negative views: pill burden, reluctance to take meds when feeling well, fear of increased risk-taking, taking ARVs associated with disclosure and having to live openly with HIV, and all are not ready to do this, especially in settings where ARV clinics have separate entrances

3.5 Harm reduction

The comprehensive harm reduction package provides an evidence-based set of interventions that can protect injecting drug users from acquiring and transmitting HIV and other blood-borne diseases while supporting other physical and mental health needs. Two studies—one focused on adult PWID with some participation of young injectors, and one focused only on YPWID—explored community views on the package in terms of access, usefulness, gaps or weaknesses and other related issues.

Table 6. Values & preferences across key population groups: harm reduction

COMMON VALUES / VIEWS / EXPERIENCES	COMMON PREFERENCES / RECOMMENDATIONS	ISSUES SPECIFIC TO INDIVIDUAL GROUPS, COUNTRIES or REGIONS
1. Criminalization is the single most important issue undermining the potential effectiveness of harm reduction.	Drug law reform is needed for many reasons; in the context of HIV, it is essential to facilitate scaling up of harm reduction as well as utilization of services.	**YPWID** are particularly at risk of juvenile detention (MENA) or forced rehab (Nepal) due to criminalization of injecting drug use and their age. Fear of such consequences discourages YPWID from seeking the harm reduction services they need.
2. Access to harm reduction is uneven within countries and across regions; criminalization of drug use and moralistic views restrict availability of services in some regions (EECA, MENA), while in regions where harm reduction has been more widely available, political and economic factors are causing a shift toward a focus on recovery and services that are seen as maintaining or supporting drug use (NSP and OST in particular) are being cut back. Most countries do not view the endorsed interventions as a comprehensive package; countries pick and choose the interventions that they are most comfortable with, or that are easiest to implement. Access often limited by distances, service disruptions and limited operating hours. Reluctance to seek services in public facilities due to stigma, provider attitudes and fear of prosecution.	***WHO is requested to take a strong position on the importance of specific components of the comprehensive package***, namely: • NSP • OST • ART • Condoms There is recognition of the importance of all nine interventions, and countries should be strongly encouraged not to de-select those that are considered problematic in certain places. Few of the people who need harm reduction services can speak for themselves, or their voices are not heard; ***WHO is in a position to speak and be heard by governments, and a stronger, more assertive position on harm reduction is needed.*** Growing focus on recovery is resulting in cutbacks in some services, making them difficult to access and affecting the emphasis and quality of services that are available. Increased availability of outreach and mobile services can offset physical access issues as well as the reluctance of PWID to seek services in public facilities.	**YPWID** are less visible than older injectors and they are often reluctant to be identified as PWID; outreach services, including comprehensive information and education, are urgently needed for this group. Age of consent is viewed as a barrier for most **YKP**, although many providers report making decisions about services in the best interest of young clients and waiving consent requirements when necessary. However, this can be risky for providers, and consent laws need to be reviewed where HIV prevention and treatment, sexual and reproductive health and harm reduction are concerned. In regions where criminalization and societal values demonize or marginalize the PWID community most brutally (especially in EECA, MENA and South Asia), action is needed to support activists and help increase awareness, tolerance and respect for human rights. The needs of **women injectors** are not being met: separate spaces to rest, access harm reduction a well as sexual and reproductive health services, take showers, get peer

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	Safe injecting spaces / low threshold centers are needed.	support. Condoms are expensive in MENA countries and usually only available in pharmacies; abstinence pushed by authorities and religious leaders. In settings where needles are difficult to get, sharing is common; lack of NSP services does not reduce injecting drug use. ***WHO is requested to take a stronger position on the availability of harm reduction in prisons.*** Loss of Global Fund resources is affecting harm reduction in some countries (Russia, Argentina).
3. Critical enablers not in place in most settings; harm reduction cannot be effective without attention to these (see Section 3.1).	Protection of human rights, poverty reduction, interventions to address hunger, homelessness, access to basic services, are all necessary to support harm reduction. Critical enablers should be added as a necessary conditions for effective implementation oof the harm reduction package.	The degree to which critical enablers are prioritized varies dramatically across regions; many PWID, experts and providers believe that there will be little progress on HIV and Hep C prevention and treatment as long as these issues are neglected.
4. Insufficient focus on Hep C, considered a much greater concern for the PWID community than HIV.	Include drug sharing equipment kits as part of the harm reduction package.	
5. Acceptability of services is affected by a lack of peers.	Peer-led service delivery, including peer support is viewed as optimal service delivery model for PWID.	
6. Targeted information needs to be more specific to the needs of PWID and less moralistic.	Topics and information need to be more specific, e.g safe injecting, vein and mouth care, OD prevention and management, prevention of Hep C. Other important topics include sexual and reproductive health, HIV prevention, and information about services that support PWID and where they can be found or contacted.	Information needs to accommodate different literacy levels and lifestyles as well as the need for broader societal awareness campaigns for tolerance and destigmatization: print material, audio-visual channels, drama, media, SMS technology.
7. Community distribution of naloxone is urgently needed.	There is an urgent need for community distribution of naloxone in all settings where people inject opiates. There are no downsides to making this intervention available on a wide scale to all PWID and their	

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	families and friends. Training should always include information about the importance of rescue breathing in all OD situations. Nasal spray and pre-loaded syringes are preferred.	