

# Partnership Guide for Drug User-Led Networks: The Good, Bad and Ugly



International  
Network of People  
who Use Drugs

# Contents

SECTION	PAGE
<b>1. Introduction</b>	<b>03</b>
<b>2. Context</b>	<b>04</b>
2.1 Current partnership guidance	04
2.2 Recognising evolving trends that are impacting meaningful involvement of communities	06
2.3 Recognising recent developments that call for meaningful involvement of communities	07
<b>3. UNAIDS definitions of community-led organisations and responses</b>	<b>09</b>
3.1 Characteristics of community-led organisations	09
3.2 Characteristics of community-led responses	11
<b>4. The foundations of meaningful and sustainable partnerships</b>	<b>12</b>
4.1 Principles for meaningful and sustainable partnerships – as defined by INPUD	12
4.2 Criteria for meaningful and sustainable partnerships	13
4.3 Minimum standards for partnership	14
<b>5. The good, the bad and the ugly</b>	<b>16</b>
5.1 What does a GOOD partnership look like?	16
5.2 What does a BAD partnership look like?	16
5.3 What does an UGLY partnership look like?	17
<b>6. How to identify good allies and partners and avoid bad allies and partners</b>	<b>18</b>
<b>ANNEXES</b>	<b>20</b>
Annex 1: AfricaNPUD experiences of partnerships with harm reduction networks and organisations	21
Annex 2: LANPUD experiences of partnership working with PLHIV and key population-led networks	23
Annex 3: PKNI experiences of a partnership with the Indonesian Ministry of Health	25
Annex 4: SANPUD experiences of partnership with INPUD	27
Annex 5: VOLNA partnership experiences in Ukraine	29

## 1. Introduction

Partnerships have always been important to the development of drug user-led organisations and networks, with many having emerged with financial and operational support from harm reduction organisations.

Forging meaningful partnerships can be valuable for drug user-led organisations and networks as a tactic to counter the structural stigma and discrimination faced by people who use drugs, as well as to strengthen their influence. Meaningful involvement and partnerships benefit people who use drugs and their organisations, from increasing funding and political opportunities to building organisational capacity. On the other hand, partnerships can be tokenistic or even parasitic, where 'allies' act as gatekeepers by speaking on behalf of the drug user community, actively excluding people who use drugs and drug user-led organisations, and/or competing for limited resources. This form of political manoeuvring may not always be easy to identify and articulate, given that many of these organisations frame themselves as allies, and often deploy a range of subtle (and not so-subtle) tactics to maintain the upper hand.

The aim of this partnership standards guide is to provide a practical tool to support people who use drugs to critically review emergent and current partnerships, and to enable drug user-led organisations to advocate for and negotiate meaningful partnerships that will strengthen the movement of people who use drugs and the realisation of their rights.

## 2. Context

### 2.1 Current partnership guidance

In 2011, the UNAIDS Joint Programme published Guidance for partnerships with civil society, including people living with HIV and key populations<sup>1</sup>. This document established international normative guidance and is still relevant today when considering partnerships with the UNAIDS Joint Programme. While it will hopefully be updated in the future to include recent developments as well as new internationally recognised definitions and terminology, the guidance is still valid and can be used to hold UNAIDS Secretariat and Cosponsors accountable.

The following guiding principles are taken from the 2011 Guidance agreed by the UNAIDS Joint Programme in 2011 and should continue to underpin their partnerships with drug user-led organisations.

**UNAIDS partnership with civil society, including key populations and people living with HIV, is based on the following principles.**

**Human rights:** a shared recognition of the human rights and equal dignity and value of each individual and community, and a commitment to supporting the realisation of human rights for all, including accessibility to all, gender equality and the rights of women and girls.

**Evidence-informed and ethical responses:** all processes, programmes and policies related to HIV should be grounded in evidence and based on the highest standards of ethics.

**People living with HIV as leaders:** in line with the GIPA principle, people living with HIV must be meaningfully involved in the development, implementation, monitoring and evaluation of national government and UN policies and programmes related to HIV at country, regional and global levels.

**Genuine partnership:** civil society is understood as a true partner in the HIV response; it is not an 'interest group', a vehicle through which activities can be rolled out, or a sector perceived as merely representing constituencies in need of UNAIDS assistance. Rather, civil society is a source of insight, resilience and innovation fundamental to the mission of catalysing a genuine, productive, visionary, rights-based and sustainable response to the HIV epidemic, and whose leadership, engagement and passion is essential.

**Equality:** UNAIDS regards its partnership with civil society as equally important as its work with national governments and other UN bodies.

**Country ownership:** the primacy of country ownership reflects the understanding that the key to success in the HIV response remains at the country level. To foster more widespread ownership and improve public accountability, many countries need greater support to lead their responses, and to establish accountability systems which create space for civil society to participate fully in national debate and dialogue on the governance of the response, including its financing. This is especially true in countries that are hostile to civil society, in particular key populations, or which have created barriers to the inclusion of people living with HIV

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1. UNAIDS Guidance for partnerships with civil society, including people living with HIV and key populations, 2012. [https://www.unaids.org/en/resources/documents/2012/20120124\\_JC2236\\_guidance\\_partnership\\_civilsociety](https://www.unaids.org/en/resources/documents/2012/20120124_JC2236_guidance_partnership_civilsociety)

in national responses; in these contexts, UNAIDS has additional obligations to model good practice through partnership, and this must be an institutional response, not simply based on the interest of individual staff members.

**Responsibility of the entire Joint UN Programme on AIDS:** duties and responsibilities to build strong partnerships with civil society encompass all Cosponsors and the Secretariat in country offices, regional teams and at their global headquarters. While various cadres of staff (e.g. UNAIDS Secretariat partnership advisors and social mobilisation advisors) have specific duties, working in partnership with civil society is a responsibility shared by all of UNAIDS joint programme staff.

**Strategic impact:** partnerships are results-based, dependent on shared objectives, and focused on clear desired outcomes as articulated in Getting to Sero. These include reduction of stigma and discrimination; removal of punitive laws, policies and practices; implementation of effective strategies to address underlying social determinants of HIV risk and vulnerability; and scale-up of essential services in HIV prevention, treatment care and support. Progress toward achieving these outcomes should be monitored by the UN and civil society and linked to UBRAF indicators (see Annex 6: Indicators).

**Mutual respect, cooperation, transparency and accountability:** UNAIDS must reflect in its policies, actions and approaches respect for the centrality of civil society and the meaningful involvement of people living with HIV to an effective response and conduct its business in a transparent way that inspires trust as well as facilitating the best outcomes. Civil society must adhere to processes and systems that equally respect the roles and mandates of the UN family and enable true partnership to flourish.

**Recognition of the autonomy and diversity of civil society:** civil society has the right to designate and determine its own leaders, representatives and spokespeople. UNAIDS should extend its collaborative efforts as broadly as possible, with particular attention to representatives of key populations or others who have been excluded from official processes.

**Complementary and cost-effective:** partnerships need to build on each partner's comparative advantages so that the work of each complements the other's contributions; effective partnerships are synergistic and create additionality, and working together they achieve efficiencies of scale and cost.<sup>2</sup>

Those advocating for leadership by people who use drugs, and the meaningful involvement of drug user communities can also refer to the *2024 UNAIDS Terminology Guidelines*, which recognise the evolution of the GIPA principle to encompass the meaningful involvement of all key populations. Like people living with HIV, these populations should be considered as essential partners and play leadership roles in local, national, and international responses and initiatives. The UNAIDS Terminology sets out the definition below:

Greater or meaningful involvement should specifically include women of all ages living with HIV, gender diverse people and members of key population groups to ensure their active inclusion and engagement in responses to HIV.<sup>3</sup>

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2. *UNAIDS Guidance for partnerships with civil society, including people living with HIV and key populations*, p14

3. *UNAIDS Terminology Guidelines, 2024 Guidance*, p22 [https://www.unaids.org/en/resources/documents/2024/terminology\\_guidelines](https://www.unaids.org/en/resources/documents/2024/terminology_guidelines)

## 2.2 Recognising evolving trends that are impacting meaningful involvement of communities

Drug user-led organisations, alongside other key population-led organisations, operate in an increasingly challenging environment that has the potential to affect both current, nascent, and potential partnerships. In planning, developing, and maintaining partnerships, it is important to keep in mind evolving societal and political trends – both negative and positive – that can impact the meaningful involvement of people who use drugs, as well as the potential for meaningful and sustainable partnerships with drug user-led organisations.

While the environment has become significantly more challenging in recent years, there has also been significant progress in gaining international recognition of the critical role of key population-led organisations and responses. Both negative and positive trends need to be considered when examining both existing and future partnerships, including:

- The shrinking civic space particularly for key population-led organisations, as an increasing number of governments restrict the registration of non-governmental organisations, primarily targeting those led by criminalised and marginalised communities, and introduce ‘foreign agents’ legislation that restricts non-governmental organisations receiving international funds. As a result, discrimination has increased, requiring criminalised and marginalised communities to find creative ways of organising.
- The undermining of universal human rights including through the ongoing criminalisation of key populations in many countries, that is increasingly impacting the safety and security of many key population-led organisations and the communities they serve, as well as limiting individuals’ access to and uptake of essential services.
- The flourishing anti-rights agenda in many parts of the world that has undone years of progress for the rights of marginalised communities and women, including bodily autonomy. The rise of anti-rights/anti-gender/anti-democracy movements has resulted in an increasingly fractured civil society, with many well-resourced groups now actively working against the principles of equality, equity, and the protection of rights for all individuals.
- The shrinking aid and development resources together with higher costs, have brought additional challenges for key population-led organisations who are expected to do more with less.
- The increased movement of people, both voluntary and forced, within countries and across borders caused by economic insecurities, civil unrest and conflict, as well as increasing climate related emergencies – has highlighted the needs and rights of both migrant and displaced people.
- Global pandemics such as COVID-19 have again highlighted the immense contribution of key population-led organisations and their ability to reach and serve their communities, while navigating pathways in complex and rapidly changing environments across the health and development landscape.

- **The growing recognition of the essential role of community-led organisations and responses** including key population-led organisations, has occurred alongside increased evidence demonstrating the effectiveness of community-led approaches, and an evolution of definitions and language used by the UNAIDS Joint Programme to talk about the added value of key population-led organisations and responses.

### **2.3 Recognising recent developments that call for meaningful involvement of communities**

Drug user-led organisations, alongside other key population-led organisations, worked with the UNAIDS Joint Programme, member states, and multilateral and bilateral donors in developing strategy documents that clearly set out a commitment to community-led responses and internationally agreed targets in relation to communities delivering services and advocacy goals. These include the Global AIDS Strategy 2021-26<sup>4</sup>, the 2021 Political Declaration on HIV and AIDS<sup>5</sup>, the Global Fund Strategy 2023-2028<sup>6</sup>, and PEPFAR's five-year strategy<sup>7</sup> launched in 2022. These can be referenced in advocacy for greater recognition of drug user-led organisations and community-led responses.

Evolving priorities and approaches set out in key donors' strategies can also have a strong influence over what – and who – gets funded and may also influence other civil society organisations' willingness and interest in partnerships with drug user-led organisations. This shift in donor interest in funding key population-led organisations and responses requires careful consideration of the motivations of organisations and individuals approaching drug user-led organisations with proposals to consider collaboration or partnership working. Motivation based primarily on an organisation or individual having access to resources designated for key populations, rather than a commitment to strengthening the capacity and effectiveness of community-led organisations and responses, can impact whether the partnership is experienced by the community as good, bad, or ugly.

#### **The Global AIDS Strategy 2021–2026**

The Global AIDS Strategy highlights the importance of differentiated responses that meet the needs of people, communities, and countries in all their diversity, and it highlights that equal importance must be given to enabling environments and community-led responses as to biomedical interventions. It also makes clear that communities must be at the forefront of efforts and must be fully empowered to play their crucial roles, and that a transformative and sustainable HIV response is only possible with fully recognised, empowered, resourced, and integrated community-led approaches.

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4. Global AIDS Strategy 2021-2026: End Inequalities. End AIDS

<https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>

5. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030

[https://www.unaids.org/en/resources/documents/2021/2021\\_political-declaration-on-hiv-and-aids](https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids)

6. Fighting Pandemics and Building a Healthier and More Equitable World: Global Fund Strategy (2023-2028)

<https://www.theglobalfund.org/en/strategy/>

7. PEPFAR's five-year strategy: Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030

<https://www.state.gov/pepfar-five-year-strategy-2022/>

However, the strategy also recognises that:

While communities are pivotal in the HIV response, the capacity of community-led responses, key populations and youth to contribute fully towards ending AIDS by 2030 is undermined by acute funding shortages, shrinking civic space in many countries and a lack of full engagement and integration in national responses. The Strategy outlines strategic actions to provide community-led and youth-led responses with the resources and support they need to fulfil their role and potential as key partners in the HIV response.

**The 2021 Political Declaration on HIV and AIDS targets:**

1. In the *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030*, member states committed to the community **30-80-60 targets**, which state that by 2025, communities should deliver 30% of testing and treatment services, 80% of HIV prevention services, and 60% of programmes supporting the achievement of societal enablers.
2. The **10-10-10 targets**, which state that by 2025, less than 10% of countries will have punitive legal and policy environments, less than 10% of people living with HIV and key populations will experience stigma and discrimination, and less than 10% of women, girls, people living with HIV, and key populations will experience gender inequality and violence.

**The Global Fund Strategy 2023-2028** includes a number of objectives that commit to reinforcing community and broader civil society leadership. Key changes from previous strategies include:

1. A more systematic approach to supporting the development and integration of community systems for health, recognising the vital role they play in combatting the three diseases and reinforcing system resilience and sustainability.
2. A stronger role and voice for communities living with and affected by the diseases, reinforcing this unique strength of the Global Fund partnership and tackling barriers to effective participation and leadership, to put the most affected communities at the centre of everything we do.
3. Intensified action to address inequities, human rights, and gender-related barriers, scaling up and strengthening current activities, building on our experience, and raising our level of ambition.

**PEPFAR's Five Year Strategy - Fulfilling America's Promise to End the HIV/AIDS Pandemic by 2030** includes an enabler on community leadership which commits to a greater focus on strengthening community leadership and integration of community voices at all stages of programme design, delivery, and monitoring. The document highlights the need to ensure that underrepresented communities are adequately capacitated to lead discussions and decision-making on critical aspects of prevention and treatment that impact their communities. It also notes the importance of supporting the scale-up of community-led monitoring and addressing stigma and discrimination.

### 3. UNAIDS definitions of community-led organisations and responses

From 2020 to 2022, representatives of governments, community-led organisations – including key population-led organisations – other civil society organisations, and donors, as members of a Multistakeholder Task Team established by the UNAIDS Programme Coordinating Board, jointly deliberated on definitions and recommendations for scaling up and reporting on community-led responses and community-led organisations engaged in the AIDS response. The recommendations were accepted, and the definitions for community-led organisations and community-led responses below were approved and adopted by the UNAIDS Joint Programme during the Programme Coordinating Board in December 2022<sup>8</sup>.

**Community-led organisations, groups and networks** engaged in the AIDS response, whether formally or informally organised, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organisations, groups, and networks engaged in the AIDS response are self-determining and autonomous, and not influenced by government, commercial, or donor agendas<sup>9</sup>. Not all community-based organisations are community-led.<sup>10</sup>

Organisations led by key populations (defined by UNAIDS as people living with HIV, gay men and other men who have sex with men, people who use drugs, prisoners, sex workers, and trans and diverse gender people) and organisations led by women and youth (defined by UNAIDS as priority populations facing increased vulnerability to HIV) are seen as different types of community-led organisations. Therefore, the UNAIDS definition of community-led organisations also applies to those led by people who use drugs and other key populations.

Key population-led organisations and networks, whether formally or informally organised, are entities whose governance, leadership, staff, spokespeople, members, and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies, and who have transparent accountability mechanisms to their communities. They are self-determining and autonomous, speak for themselves, and are not influenced by government, commercial, or donor agendas.

#### 3.1 Characteristics of community-led organisations

Community-led organisation – including those led by key populations – vary from small, informal groups to large, formally structured organisations and networks. Depending on their stage of

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8. Community-led AIDS Responses: Final report based on recommendations of the multistakeholder task team <https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses>

9. This statement is designed to emphasise the importance of self-determination. It does not mean there are no influences upon community-led organisations. Community-led organisations (CLO) engaged in the AIDS response do not work on their own, but together with many other stakeholders, and these partnerships are critically important. Community-led organisations may choose to take into account the positions of other stakeholders, in particular those that they work with. However, decision-making power rests with the CLO, and they should not be put under undue pressure to alter their views to suit any other stakeholder, whether that is a government, donor, or commercial body. They may come to the same perspectives as other stakeholders, but they must do this of their own free will.

10. UNAIDS Community-led AIDS Responses, p10 <https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses>

development and national legislation, they may or may not be formally registered with local or national governments.

All community-led organisations are run by people from the community being served, who are in the majority across both employees and volunteers, governing bodies, and advisory groups. People from the community inherently understand the needs and concerns of their community and can use that information to inform the priorities of the organisation. A community-led organisation's ethos and work are guided by the lived experiences and realities of the cultural, legal, and social challenges faced by the community, as well as an awareness of existing opportunities. It is vital that communities have and maintain primary responsibility for making decisions in relation to the organisation's strategy and its use of available resources.

Key population-led organisations are led by people who share experiences of stigma, discrimination, criminalisation, violence, and who shoulder a disproportionate burden of HIV infection and lack of access to health and social services in all parts of the world. As such, they are critical to the global HIV response.

While sharing the characteristics of community-led organisations, key population-led organisations are anchored in their communities through transparent accountability mechanisms that include systems to regularly gain input from and give feedback to the communities they serve. They uniquely give voice to the holistic needs of their community, reflecting and addressing issues relating to inequality, inequity, and human rights violations, including violence and lack of access to justice, as well as health issues.

### **Intersectionality**

When looking at definitions of community-led, including key population-led organisations, it is important to acknowledge the intersectionality that exists within and between communities and key populations.

Communities are made up of people with diverse, intersecting, multiple characteristics and identities – such as gender identity, age, disability, HIV status, sexual orientation, socio-economic status, ethnicity, migration, and legal status. Intersectionality needs to be acknowledged, addressed, and respected within community-led organisations and responses, and within partnerships. There are young people involved in community-led organisations that are not youth-led, and it is important that their voices are heard, and needs taken into account. There are women and girls who are involved in and served by key population-led organisations, and it is important their needs are addressed in key population-led responses. Intersectionality is also a reality across key populations, where people who use drugs may also be sex workers, trans and gender diverse, gay and lesbian, and many have experienced incarceration.

**Community-led AIDS responses** are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organisations, groups, and networks that represent them.<sup>11</sup>

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11. UNAIDS Community-led AIDS Responses, p10  
<https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses>

Responses led by key populations, women, or youth are all seen as different types of community-led responses, and all the details included in the above definition of community-led responses also apply to drug user-led responses.

### **3.2 Characteristics of community-led responses**

Community-led responses are determined and implemented by, and respond to the needs and aspirations of, the community they serve. They include advocacy, campaigning, capacity-building, education and information sharing, participatory research, service delivery, monitoring and watchdogging policies, practices and service delivery, and holding decision-makers and implementers accountable to commitments made.

Community-led responses are seen as central to the global AIDS response. They take place at global, regional, national, district, and local levels and can be implemented virtually or in person.

Community-led organisations implementing programmes have a responsibility to ensure they do no harm, planning interventions with care and assessing whether their actions could have any negative impact upon individuals or communities. Where potential harm is identified, measures to mitigate against the risk of harm must be put in place, particularly when working with criminalised and highly stigmatised populations.

In addition to the above characteristics, key population-led responses aim to strengthen both the capacity and voice of their communities, regardless of resource availability. Responses are always based on the community's needs, priorities, and the protection of human rights.

Key population-led responses are developed by and for communities. They are directly informed by, and respond to, the needs and challenges of the community and implemented by and for key population-led organisations, rather than on behalf of the community.

Key populations choose their own representatives, and how they engage in global, regional, national, and local policy and programmes. They engage on their own terms and with careful consideration to the diverse social and structural barriers faced by criminalised and marginalised communities.

A forthcoming UNAIDS Joint Programme guidance on partnering for sustainable community-led responses, including key population-led responses, will also contribute to a greater understanding of key population-led organisations and their role in community-led responses.

## 4. The foundations of meaningful and sustainable partnerships

### 4.1 Principles for meaningful and sustainable partnerships – as defined by INPUD

**Vision:** To enable and empower people who use drugs to survive, thrive, have a voice, and be included at every level of decision-making.

**Autonomy:** The autonomy of drug user-led organisations is recognised and embedded in partnership agreements and working arrangements.

**GIPA+ principle:** People who use drugs are recognised as experts, and their skills, knowledge, and ability to connect with the drug user community are valued as a critical contribution to the partnership.

**Resources:** Limited resources require all partners to ensure optimal use of funds, while at the same time ensuring that people who use drugs are equitably reimbursed for their expenses, time, and expertise.

**Diversity:** Value and respect diversity, recognising the added value of each other's unique backgrounds, knowledge, skills, and capabilities. Cultivate a safe and supportive environment for people who use drugs, regardless of which drugs they use or how they use them.

**Inclusion:** Ensure the inclusion of, and voice given to, those who are disproportionately vulnerable to oppression on the basis of their gender identity, age, HIV status, sexual orientation, socio-economic status, ethnicity, migration, and legal status. Actively foster a culture of inclusion through promoting tolerance, cooperation, and collaboration.

**Informed:** Evidence-based, objective, and up-to-date information about safe drug use, harm reduction, and prevention and treatment options for people who use drugs is shared with all partners and consistently used to inform and realign the work of the partnership.

**Terms of reference:** Clear terms of reference that set out expectations, roles, and responsibilities for all partners<sup>12</sup>, must be mutually agreed prior to commencing any partnership work. They should be reviewed on a regular basis for compliance and any adjustments required. Where shared responsibilities are identified in a terms of reference, all partners involved must commit to regular communication and updates.

**Decolonisation<sup>13</sup>:** Partnerships should commit to modelling collaboration with people who use drugs rather than perpetuating a colonial approach and mindset.

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12. Partners may include a wide range of stakeholders including United Nations agencies, national or local government institutions, international or national non-governmental organisations, researchers and academics, as well as other civil society actors.

13. Decolonisation is the process of deconstructing colonial ideologies of the superiority and privilege of Western thought and approaches. Decolonisation involves dismantling structures that perpetuate the status quo and addressing unbalanced power dynamics.

**Do no harm:** All partners have a responsibility to assess whether the partnership could have a negative impact upon people who use drugs or drug user-led organisations. Where necessary, they should agree upon and put in place measures to mitigate the risk of harm. In particular, burnout is increasing, especially in contexts where there are shrinking resources, increasing workloads, and deteriorating enabling environments, including emerging well-funded anti-rights movements. All partners need to be aware of the tensions and demands that different partners are facing and identify flexible, supportive strategies for partners whose team members may be experiencing or at risk of burnout.

## 4.2 Criteria for meaningful and sustainable partnerships

Drug user-led organisations and networks have identified the following criteria for their communities' meaningful involvement in sustainable partnerships. These criteria also apply to meaningful involvement in other collaborations, such as consultations or attending meetings.

- ✓ The drug user-led organisations choose how they are represented, and by whom.
- ✓ The drug user-led organisations choose how they engage in the process.
- ✓ The drug user-led organisations choose whether to participate or not.
- ✓ The drug user-led organisations have an equal voice in how partnerships will be managed.
- ✓ A transparent process<sup>14</sup> for decision-making exists and allows time for consultation (between drug user-led organisations and/or between drug user-led organisations, networks, and their constituencies).
- ✓ Clear Terms of Reference for individuals from the drug user community involved in the partnership exist to specify that they represent their constituencies and/or organisation, and not their personal interests.
- ✓ Drug user-led organisations and networks, along with partners, have an equal voice and power.
- ✓ Drug users are not seen only as beneficiaries of programmes but are involved at all levels in programmes (design, development, implementation, monitoring and evaluation, management, advisory committees, and governance) and policy development and review.
- ✓ Translation and interpretation are always provided, if required, to enable informed decision-making and participation.
- ✓ Clear remuneration criteria have been established and agreed for out-of-pocket expenses, and appropriate and equitable mechanisms for remuneration of out-of-pocket expenses must be in place, including for those without access to financial institutions.
- ✓ Meaningful involvement must not be limited to ad-hoc involvement in consultations or as peer educators but must value community members as equals and experts.

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14. A transparent process includes:

1. Comprehensive information about the decisions to be made by the community was made available in a timely manner and in the languages spoken by sex workers in the country (including migrants).
2. Documentation of any consultations that occurred with the drug user community across the geographic area.
3. 1 month, at least, to allow for consultation at national level.

### 4.3 Minimum standards for partnership

Drug user-led organisations and networks identified the following minimum standards that represent the drug user community's minimum expectations for partnerships that should be applied across national, regional, and global levels.

**Inclusion and diversity:** The partnership must recognise and respect the unique contribution of the lived experiences of people who use drugs, including the diversity of experiences, expertise, and knowledge, and seek to ensure age, gender, geographic, and racial diversity are considered.

**Legitimate and balanced representation:** Established (and documented) mechanisms and processes are in place to ensure the community is represented by genuine nominees, chosen through a transparent community-led process that seeks to ensure diverse representation from the drug user community.

**Investment in leadership:** Resources and time are allocated to support organisational and individual leadership development, if required, to address power imbalances across drug user-led organisations and other partners. Strengthening capacity, and growing trust and respect within partnerships, allow partners to call out gatekeeping by and within civil society that undermines legitimate and balanced representation from drug user-led organisations.

**Active participation:** Resources and time are allocated to support consultation within drug user-led organisations as an integral component of partnership decision-making related to needs assessment, budgeting, planning, implementation, monitoring, and evaluation. Resources should also be allocated for strengthening community capacity, if required, to ensure effective and sustainable community participation.

**Regular monitoring:** Ensure drug user-led organisations are equal partners in scrutinising compliance with partnership policies, protocols, and guidance, as well as financial management and performance associated with the partnership.

**Appropriate level of communication and information sharing:** A communication protocol is mutually agreed to ensure that all communication and information sharing happens in an accessible and timely manner. This should include mutually agreed timelines for advance notice required for meetings and community consultations; timelines for receiving, reviewing, and consulting on documents; and ensuring that information and communication are accessible and available in languages other than English, if required. In addition, all international normative guidance relating to community-led organisations and responses should be shared with all partners as part of the appropriate level of information sharing.

**Contractual arrangements for partnerships:** Appropriate contractual arrangements are mutually agreed upon with drug user-led organisations, including: the dispersal of funds and financial management systems that are appropriate for community-led organisations; data collection that is both appropriate and deemed as essential, while at the same time does not overburden the community-led organisations; and data and outputs that are co-owned to allow dissemination in accessible formats to drug user communities.

Monitoring compliance with these minimum standards, and determining whether the partnership is sufficiently effective and equal, will involve assessing the level of effective communication and two-way information sharing; the engagement of partners in establishing the partnership's agenda; the sharing of control and the level of influence of each partner; evidence of mutual accountability; and evidence that mechanisms, structures and processes are transparent (and all partners agree this is the case).

## 5. The good, the bad and the ugly

### 5.1 What does a GOOD partnership look like?

Key elements include **mutual respect and inclusion**, ensuring that people who use drugs are actively involved in the decision-making processes, and that their voices are heard and acted upon. Good partnerships focus on **capacity strengthening, technical support, and training**, ensuring that drug user-led organisations have the necessary knowledge and skills, including organisational policies and procedures, to undertake advocacy and implement services. These partnerships also build on **shared goals**, ensuring common objectives across the partnership that will benefit people who use drugs. They stress on **evidence-based approaches**, ensuring the partnership utilises research and data, including community-led research, to inform advocacy and programmes that are effective and responsive to the needs and priorities of people who use drugs. Good partnerships also prioritise on **community engagement**, ensuring the partnership fosters greater understanding of and support for people who use drugs with the broader community. Finally, these partnerships also focus on **joint advocacy efforts**, ensuring the voices of people who use drugs are at the centre in advocating to policy changes that protect and respect the rights of people who use drugs.

**Potential impact on health and human rights:** Good partnerships are crucial for addressing both health and human rights. Such collaborations can lead to better resourced and more effective harm reduction programmes, improved access to healthcare services, and stronger advocacy for better laws, policies, and practices that will protect the rights of people who use drugs. Good partnerships help address the complex and multifaceted issues faced by people who use drugs, leading to healthier communities and more effective public health outcomes.

### 5.2 What does a BAD partnership look like?

Common elements include partners who are entrenched in a **beneficiary-provider approach**, seeing themselves as the experts and people who use drugs as passive recipients of their expertise. They often come with a **predetermined workplan and budget**, with community deliverables predefined and no flexibility allowed during the programme. Bad partnerships expect drug user-led organisations to operate on **minimal budgets** that fail to adequately cover realistic staff expenses, sessional workers costs, and overheads. They are often **not willing to share power** or meaningfully include people who use drugs in decision-making. Instead, they **speak on behalf** of people who use drugs rather than creating platforms for them to speak for themselves. These partnerships often **falsely claim to be as community-driven or community-led**, when they do not give opportunities for or listen to community input.

Discussions with SANPUD when developing their case study led to a conclusion that “the bigger the programme, the less of a partnership it becomes; and the larger the grant, the more controlling the conglomerate.”

**Potential impact on health and human rights:** Bad partnerships often perpetuate the stigmatisation of people who use drugs, now recognised as one of the causes of poor health outcomes and human rights violations. Bad partnerships fail to meaningfully involve and utilise the expertise and commitment of people who use drugs, now widely recognised as a critical component in realising health and human rights. As such, this will limit the potential impact of both advocacy and programmes.

### 5.3 What does an UGLY partnership look like?

One organisation described them as “partners who come in the face of Moses, but they’re followers of Pharaoh.” Common elements include partners who **falsely claim to have consulted** with people who use drugs on proposals but have not disclosed vital information about the programme budget and workplan. Their approach often **defines people who use drugs as patients or beneficiaries** who have zero influence on the services provided to them. Some ugly partnerships encourage and offer transitional administrative, financial management, and hosting solutions for groups of drug users who want to establish organisations in challenging social and legal contexts but instead **create a dependency and exert absolute control**. These partners seek to **determine or inappropriately influence leadership** of a drug user-led organisation, to the detriment of the organisation and the drug user community. Ugly partnerships may include those who **restrict the role of drug user-led organisations** to implementing limited activities or participating in activities carried out by the partner organisation. These partners also undertake to facilitate the legal registration of an organisation but consistently fail to do so thereby **maintaining dependency** of the drug user-led organisation, despite funds being available. As fiscal hosts for a drug user-led organisation, some partners **repeatedly delay the transfer of funds** for activities and salaries, impacting their ability of organisations to meet donor deliverables. As fiscal hosts, they also repeatedly fail to honour their obligation to provide financial reports for donors that impact upon the credibility of drug user-led organisation. These ugly partnerships use **inappropriate or offensive language in communications** undermining any meaningful partnership and shows a lack of respect for people who use drugs.

**Potential impact on health and human rights:** Ugly partnerships discriminate against and exploit people who use drugs and drug user-led organisations, where both discrimination and exploitation are recognised as causes of poor health outcomes and human rights violations. Ugly partnerships also breach many donors’ ethical standards. These partnerships undermine the realisation of both health and human rights of people who use drugs.

## 6. How to identify good allies and partners and avoid bad allies and partners

A number of drug user-led networks and organisations contributed to the following questions they consider before deciding whether they enter into collaborations or partnerships with other organisations or donors<sup>15</sup>.

It is worthwhile to ask potential partners questions and/or requesting documentation to enable your organisation to determine whether they are likely to be a good, bad, or ugly partner. Refusal to answer questions or provide documentation is a sign they may not be a good partner.

- i. Are the mission and goals of the proposed partner consistent with the mission and goals of your organisation?
- ii. Is the partnership work proposed in alignment with the mission of your organisation and with your organisation's current strategic priorities?
- iii. Does the proposed partner's track record show compliance with and consideration for ethical practices? Do they walk the talk?
- iv. Are there any conditions attached to the proposed partnership that will not align with your organisation's meaningful involvement criteria?
- v. Are there any ethical reasons why the drug user community may not welcome working with the proposed partner?
- vi. Do any of the proposed partners' activities conflict with the values of your organisations?
- vii. Do any of the proposed partners' financial interests conflict with the values of your organisation?
- viii. Are there any conditions attached to the proposed partnership that will place a financial burden on your organisation?
- ix. Is the proposed partner committed to ensuring that the employment rights of full-time and part-time staff, sessional workers, and volunteers are respected?
- x. Is the proposed partner committed to supporting employment and career development for drug users wishing to further develop their work experience and advance their careers?
- xi. If funding is being offered as part of the partnership, is the budget sufficient to cover additional administration, financial management, and staff costs, as well as activities?
- xii. Will the funding and any conditions attached to it allow for appropriate, equitable, and timely remuneration for staff, sessional workers, and out-of-pocket expenses, in line with your organisation's procedures?

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15. A number of donors now refer to themselves as partners, however, the power dynamic precludes such partnerships from being equal even if it is a good partnership.

- xiii. Is the source of funding offered by the proposed partner known? Would accepting it damage the reputation of your organisation or open up allegations of money laundering?
- xiv. Is the proposed partner committed to ensuring the safety and security of the drug user community and your organisation if they intend to publicise the partnership?

**Sometimes we have to say 'no, thank you' to potential allies, partnerships, and/or funding!**

# ANNEXES

## National and Regional Case Studies

## ANNEX 1

# AfricaNPUD experiences of partnerships with harm reduction networks and organisations

Partnerships between drug user-led organisations and harm reduction organisations in Africa often emerged from outreach efforts led by civil society organisations who understood the importance of including those directly affected by drug policies in the decision-making processes, as well as the growing recognition of the need for effective harm reduction strategies. The original goal of such partnerships was to create a more inclusive and effective approach to drug use and people who use drugs in Africa, emphasising health and safety for individuals and communities through:

- 1. Community advocacy:** People who use drugs being given space to advocate for their human rights and access to health services, highlighting the gaps in existing health policies and programmes, and the need for comprehensive and tailored interventions.
- 2. Formation of networks:** The establishment of networks and support groups for people who use drugs, fostering a sense of community and collective action, and amplifying the voices of people who use drugs in policy and programme discussions about drug-related issues.
- 3. Policy engagement:** Engaging with policymakers to advocate for drug policies that prioritise health and human rights, rather than punitive measures.
- 4. Education and awareness:** Educating both the public and healthcare providers about harm reduction to reduce stigma and improve the treatment and care available to people who use drugs.

However, many drug user-led organisations and networks across Africa report that they have not seen substantive progress in the above focus areas. The partnership goals often remain aspirational due to limited resources being made available, particularly to drug user-led organisations, and the highly competitive environment. This is exacerbated by insecurities from within harm reduction organisations and other stakeholders who feel that people who use drugs should remain 'patients' or 'beneficiaries'.

Drug user-led organisations have faced significant challenges in partnerships with harm reduction organisations and networks, including:

**Lack of trust and engagement:** Drug user-led organisations have reported that their concerns and voices are not heard or acted upon by harm reduction organisations. The lack of reliable data and population size estimates across the region has led to the perception that harm reduction organisations prioritise donor agendas and their own operational goals over the actual needs and priorities of drug user communities in Africa. This disconnect has resulted in limited participation in programmes and activities designed without meaningful involvement of people who use drugs.

**Inadequate representation:** The lack of leadership by, and meaningful involvement of, people who use drugs in harm reduction organisations and networks, along with the failure to reflect and/or embrace the lived experiences and realities of people who use drugs, has led to priorities

and programmes that do not resonate across the drug user community. This also heightens the reluctance to fund drug user-led organisations to provide harm reduction services. This lack has resulted in programmes that do not address the holistic needs of people who use drugs, in particular the provision of comprehensive health and social services that enable their greater engagement with harm reduction.

**Stigmatisation and discrimination:** Some harm reduction organisations and networks continue to perpetuate stigma against people who use drugs, by framing them solely as ‘patients’ or ‘beneficiaries’ of specific interventions – often with an increasing focus on abstinences – rather than as active and equal partners in the development and implementation of comprehensive harm reduction, health, and social services. This attitude has fostered a sense of alienation among people who use drugs, making them less likely to engage in discussions with harm reduction organisations about improving harm reduction services in Africa.

**Misalignment of goals:** Harm reduction organisations’ operational goals are too often not aligned with the immediate needs of people who use drugs. These goals focus heavily on the quantitative aspects of reaching targets and reporting to donors, while disregarding qualitative aspects of health and well-being. This focus fails to address urgent socio-economic needs of people who use drugs, leading to frustration and disillusionment. This misalignment results in a lack of effective and sustainable support systems for people who use drugs, exacerbating the challenges they face in their daily lives.

**Competitive and limited resource allocation:** Competition for limited resources has widened the rift between drug user-led organisations and harm reduction organisations in many African countries as resources continue to be disproportionately allocated to civil society organisations that are not drug user-led. This continuing trend ignores the growing evidence and international normative guidance and targets that recognise community-led organisations as critical in tackling health inequalities and serving the needs of key populations, including people who use drugs. In Kenya, despite the increased availability of needle and syringe program and Opiate Agonist Therapy (OAT), HIV prevalence among people who inject drugs in Kenya has slightly increased. This indicates that essential harm reduction services are not reaching or meeting the needs and priorities of people who use drugs, which could be more effectively met by drug user-led organisations.

This case study highlights the complexities and challenges of building effective and sustainable partnerships between drug user-led organisations and harm reduction organisations, particularly where there is competition for resources with community-based harm reduction organisations.

For partnerships to be more effective, it is crucial to foster genuine engagement, ensure appropriate representation of people who use drugs at all levels, align goals, and address internalised and institutional stigma. Building trust and genuine collaboration can lead to more positive outcomes for people who use drugs and improve overall harm reduction efforts in Africa.

**NOTE:** While this case study was drafted by AfricaNPUD, similar experiences are reported from drug user-led organisations and networks across the world.

## ANNEX 2

# LANPUD experiences of partnership working with PLHIV and key population-led networks

In 2018, HIVOS, a Global Fund Principal Recipient, was asked by the Global Fund to include regional key population-led networks in the Alliance for Positive Leadership plus Key Populations (ALEP+PC) to request and execute a Global Fund multi-country grant in Latin America. The Alliance began with networks of people living with HIV such as ICW Latina, ITPC-LATCA, J+LAC, MM+, REDCA, and REDLA, and later invited other key population networks: LANPUD, GayLatino, PLAPERTS, and RedLACTrans to join the Alliance. The Alliance submitted the proposal to the Global Fund in collaboration with HIVOS as the Principal Recipient.

While the partnership was not initiated by the Latin American Network of People who Use Drugs (LANPUD) or the other regional key population-led networks, the goal of ALEP+PC was one that they all shared, that is to improve the quality of life for people living with HIV and key populations through focusing on reducing stigma and discrimination, inequities, gender inequalities, and violence. The majority of activities were focused primarily on advocacy regarding human rights, access to HIV treatment, and community-led monitoring in 11 Latin American countries. Each of the Alliance partners was allocated a budget to implement activities that contributed to the overall partnership goal and focus, and the four regional key population-led networks chose to work together on intersecting issues.

This is the first time a drug user-led network has been included as recipient of a Global Fund grant in Latin America, yet there has been little or no funding for harm reduction in the region. LANPUD decided to focus its advocacy work on reducing stigma and discrimination against people who use drugs, with an intersectional focus, as addressing stigma and discrimination was a shared concern across the key populations of gay men and other men who have sex with men, sex workers, and transgender women.

The four regional key population-led networks collectively developed a survey based on the HIV Stigma Index, focusing on community experiences – beyond only healthcare settings – of violence, stigma, and discrimination. This was coordinated by LANPUD and carried out by national members of the regional key population-led organisations in Bolivia, Costa Rica, Ecuador, El Salvador, Honduras, Panama, Paraguay, and Peru.

LANPUD also developed an online platform to report and document human rights violations against people who use drugs in Latin America. While it is still in the pilot phase in 2024, it will provide a long-term resource to monitor human rights violations against people who use drugs. In addition, LANPUD negotiated a budget to develop a community-led legal assessment tool to document policies and experiences of people who use drugs in relation to the right to health, non-discrimination and arbitrary detentions in 10 countries in Latin America. The study was coordinated by LANPUD and developed and implemented by people who use drugs.

Separate to the partnership within ALEP+PC, LANPUD also received a technical assistance grant from the Global Fund Communities, Rights and Gender Strategic Initiative to investigate and document the status and inclusion of people who use drugs in the Global Fund national processes. This research, done in partnership with Harm Reduction International, found that in many countries people who use drugs are not considered as key populations, and none of the Country Coordinating Mechanisms (CCM) in the 11 countries that are part of the ALEP+PC multi-country grant include a representative of people who use drugs. Being a partner in ALEP+PC has strengthened LANPUD's capacity to advocate for the recognition of people who use drugs as a key population in Latin America and representation on CCMs.

Through this partnership, LANPUD has been able to:

- Generate evidence about the lived experiences and realities of people who use drugs that challenges prevalent misinformation about the impact of criminalisation and stigma and has brought to light the barriers that people who use drugs face in accessing HIV treatment.
- Raise awareness among communities of people living with HIV and other key populations about the criminalisation and stigma faced by people who use drugs.
- Strengthen collaboration with other regional key population-led networks.
- Raise the profile of and amplify discussions about people who use drugs in the HIV response in Latin America.
- Gain experience implementing a multi-country community-led programme funded by the Global Fund.

Lessons learned:

- The need to strengthen the safe space within our network and provide more support and training to community members participating for the first time in such a large and demanding programme. In particular, the need for more support and preparation for national and local representatives nominated to participate in both virtual and face-to-face meetings with other community-led networks, civil society organisations, and government institutions.
- The need to improve coordination and communication with other community-led networks and ensure personal issues do not interfere with the partnership or process.
- The importance of taking care of one another and building support structures within our networks and within the drug user community to protect cohesion, solidarity, and relationships with our peers. Without this, we will not overcome the challenges faced by people who use drugs.

### ANNEX 3

## PKNI experiences of a partnership with the Indonesian Ministry of Health

This partnership was developed following advocacy and demand generation by PKNI and people who use drugs for accessible Hepatitis C testing and treatment in Indonesia, including rallies and protests targeting the Indonesian Ministry of Health and its Policy Institute for Procurement of Goods and Services (LKPP), that resulted in the successful inclusion of Hepatitis C treatment in national procurement by the Ministry of Health. Following this success, the Ministry of Health planned to launch a free national Hepatitis C testing and treatment programme in 2019. It was recognised that for the programme to be successful, there was a need to ensure the preparedness of the health system, including updating the national Hepatitis C management guidelines to align with the latest guidance from the World Health Organisation. This would simplify the process from diagnosis through to treatment, which would increase efficiency while also making costs more affordable. PKNI began collaboration with the Ministry of Health and other experts, such as the Indonesian Liver Research Association (PPHI), as part of the writing team to develop the Brief Guide to Hepatitis C Management. PKNI supported the Ministry of Health to accelerate the printing of the management guideline documents so that they could be disseminated around the country without delay.

The Brief Guide to Hepatitis C Management, which complemented the government regulations regarding the management of Hepatitis Virus issued by the Indonesian Ministry of Health in 2015, was officially launched in Jakarta on 9 December 2017 by the Director of Prevention and Control of Transmitted Diseases of the Ministry of Health, with the launch being covered in the national media. The document provided health workers with accessible, easy-to-understand information regarding managing Hepatitis C in healthcare facilities, but also included guidance on providing comprehensive services in prevention, treatment, and support for people who are vulnerable to or living with Hepatitis C. The existence of the Brief Guide to Hepatitis C Management accelerated the process for preparing for the national Hepatitis C testing and treatment programme, and PKNI worked with PPHI in training healthcare workers in preparation of the expansion of Hepatitis C testing and treatment services.

At the same time PKNI, as the national network of people who use drugs, campaigned for urgent access to Hepatitis services, as the drug user community had the highest prevalence of Hepatitis C and heightened co-infection with HIV. While the number of people who use drugs accessing Hepatitis C services increased, it was not significant, and PKNI realised they needed to provide more information to the drug user community and integrate knowledge about Hepatitis C testing and treatment services as a component of harm reduction programmes.

While the guidelines do not explicitly identify people who use drugs as the main target of the national Hepatitis C testing and treatment programme, the positive collaboration between PKNI and

the Indonesian Ministry of Health contributed to the recognition of drug user community as a key population with the highest prevalence of Hepatitis C and co-infection with HIV. This led to Hepatitis C testing and treatment in health services becoming more accessible for people who use drugs, with people who use drugs receiving particular attention in the implementation of free Hepatitis C testing and treatment as a part of national programme. Ongoing efforts continued in relation to reducing treatment costs and ensuring the availability of effective drugs.

The partnership and collaboration with the Ministry of Health demonstrated a strong, shared commitment to improve Hepatitis C treatment in Indonesia, including expanding access to testing and treatment for people who use drugs and other vulnerable populations. This collaboration strengthened meaningful community involvement with both non-governmental organisations as well as governments. It also encouraged the implementation of harm reduction outreach programs that are more effective in conveying knowledge related to Hepatitis C and can encourage early detection and initiation of Hepatitis C treatment in the community. Additionally, it also supported increased awareness campaigns to increase public understanding of Hepatitis C, how to prevent it, and the importance of early treatment.

## Annex 4

# SANPUD experiences of partnership with INPUD

The partnership between South African Network of People who Use Drugs (SANPUD) and INPUD has its roots in 2018, when SANPUD received seed funding to cover core costs as one of the partners in a consortium of drug user-led organisations led by INPUD. Funds secured for the consortium from the Robert Carr Fund made it possible for the drug user movement in South Africa that was predominantly run by volunteers to formalise the network and establish a head office and site offices in some provinces, as well as being able to hire staff.

However, the partnership with INPUD went beyond simply providing funds. As the lead agency in the consortium, INPUD did not micro-manage us as a partner, but rather asked what our needs were. As we were at the start of our organisational journey and development, we were not 100% sure what our needs actually could be, so the INPUD team provided on-site technical assistance in Cape Town to accompany us in establishing the foundations of the organisation. The INPUD team supported SANPUD in learning, rather than telling us what to do and how. They shared their experiences as a drug user-led network, providing invaluable guidance in helping us work through our options on governance, financial management, and organisational structure that would ensure we could meet compliance requirements of donors, as well as working with us to develop a clear vision and mission and branding. Having provided the initial technical assistance, they did not abandon us but continue to accompany us on our organisational development journey – with in-person when the opportunity arises and through regular online meetings.

Working with INPUD and learning from their expertise, SANPUD has been able to grow and learn. Whether it was through the initial technical assistance, ongoing peer-to-peer training, annual monitoring and evaluation meetings, or the monthly virtual check-ins to see where we are at as an organisation, SANPUD has felt fully supported by INPUD throughout the partnership.

What worked particularly well, in practice:

- The opportunity given by the in-depth discussion space (2-3 days) at the beginning of the year to reflect and discuss plans for the year, that are then fleshed out with all the consortium partners.
- Monthly virtual check-in meetings that are held to discuss activities and finances, raise concerns, and resolve issues before they become a problem.
- The opportunities provided by being included and invited to join other activities that strengthened our organisation.
- Being asked how we would like to grow/be strengthened, and thereafter the INPUD team provides the support, whether it be resources or people, to make it happen.

- The simple annual budget and workplan template (usually combined into one, which is super simple) and the annual budget available. SANPUD then determines workplan activities and budget lines as per the drug user community and organisational needs. It is important to stipulate this because this does not usually happen. In most partnerships' programmes, a subtle stigma is present where we are given very strict guidelines. Most of the time, the activities and budget lines are pre-defined, and we are rarely given the space to determine our own priorities and activities. In being part of larger funding streams, especially those on global and regional levels that include other key population-led organisations, micro-managing is evident. It feels like a tick-box exercise where we are told what to do, and that we must comply with the pre-defined budget lines and warned that if we deviate from those strict budget lines the expense will be disallowed.

Our experience in partnering with INPUD has been unlike other partnerships. It is likely the fact that INPUD is also a peer-led network, and that their vision and mission are similar to SANPUD's. However, the leadership, guidance, and support given by INPUD, as well as the oversight on behalf of Robert Carr Fund, has demonstrated a deep understanding of community-led organisations and networks. Their recognition of our need to be able to self-determine the priorities of people who use drugs has shown us what meaningful engagement with the drug user community can look like. This is in contrast to the tokenistic effort that we have experienced with other programmes and projects.

## Annex 5

# VOLNA partnership experiences in Ukraine

VOLNA<sup>16</sup> is recognised as the national organisation led by and representing the community of people who use drugs in Ukraine. Its overall goal is for people who use drugs to have equal rights in Ukraine, enshrined in laws and regulations, through the decriminalisation of drug use and people who use drugs, as well as the development of quality services for people who use drugs, to ensure access to health and human rights.

To achieve decriminalisation, VOLNA focuses on the following:

- Community participation in shaping drug policy in Ukraine;
- Community advocacy for changes to legislation, regulations, orders, and standards of care;
- Community-led monitoring of changes in legislation, regulations, orders, and standards of care,
- Community-led monitoring of quality of services provided to people who use drugs;
- Strengthening the capacity of people who use drugs to protect their rights through access to paralegal services; and
- Development of strong partner network and increased participation in drug policy-related platforms.

VOLNA was directed by its membership of people who use drugs to intentionally build and strengthen partnerships with organisations and networks that share its vision, understanding that VOLNA cannot achieve significant results in the areas of legislative and policy change alone.

**At a national level:** VOLNA has collaborated with government and civil society organisations and has been an active member of the National Council on Tuberculosis and HIV/AIDS under the Ukrainian Cabinet of Ministers, the Ukrainian Ministry of Health intersectoral working group on drug policy strategy and its implementation plan; Fight for Health platform, that includes civil society and Ukrainian Members of Parliament; and the national platform of key population-led organisations.

In addition, VOLNA has partnered with 37 organisations through DRUGPOLICY.UA and the UNAIDS Joint Programme, including UNODC, the cosponsor responsible for people who use drugs; as well as national civil society organisations *Alliance Consultancy* and *Alliance for Public Health*; the national network *100% Life*; and other national key population organisations.

### **Examples of national-level collaboration and partnerships achievements:**

As a member of the Ukrainian Ministry of Health working group that developed the Ukrainian drug policy strategy that will be in place until 2030, VOLNA put forward the concept of decriminalisation.

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16. Charitable Organisation Charitable Foundation All-Ukrainian Union of People with Drug Dependence (COCF VOLNA)

The active participation of people who use drugs succeeded not only in preventing new legislation<sup>17</sup> that would have further criminalised people who use drugs, but also led to the drafting of alternative legislation that focuses on decriminalisation and human rights. This bill has now been registered for consideration by the Ukrainian Parliament.

In 2020, the Ministry of Social Policy of Ukraine approved a standard for the provision of psychosocial rehabilitation services. However, this standard is not aligned with Order No. 200 of the Ministry of Health of Ukraine, which regulates the provision of daily doses of opioid agonist therapy (OAT). This leads to a lack of a clear and consistent approach between the two Ministries in determining daily doses for people who use drugs, as well as a lack of clarity in developing and providing additional social support services for them.

VOLNA continues to advocate for changes to Ministry of Health regulations, orders, and standards of care to ensure the highest quality of treatment and care is consistently provided to people who use drugs across Ukraine.

Partnership working has also supported the development of paralegal services that enable people who use drugs to protect their rights in 19 regions across Ukraine.

The successful expansion of VOLNA's partner network has increased people who use drugs' participation in drug policy-related platforms, including submitting two civil society proposals to two public consultations on drug policy strategy and the submission of joint proposals to central authorities.

Community-led monitoring has been implemented, and the evidence collected by people who use drugs is being used to address issues and problems related to Opioid Substitution Therapy and Suboxone Maintenance Treatment, through regular discussions with the public health centre. Strong partnerships have led to the results of community-led monitoring being transformed into targeted proposals that address gaps in services for people who use drugs. One such example during the ongoing war in Ukraine is that, despite the lack of a strategy, OAT services have not only been maintained but expanded in new cities, thanks to technical assistance from VOLNA, Alliance for Public Health, 100 % Life, the Central Public Health Unit of the Ukrainian Ministry of Health, and other partners.

The national partnerships have amplified the impact VOLNA has had in supporting people who use drugs in Ukraine through increased resources, strengthened advocacy, and improved engagement in drug policy development. In addition, national partnerships enabled the continuation and expansion of services and support for people who use drugs during both the COVID-19 pandemic and the ongoing war.

**At the regional level:** VOLNA is a member of the Eurasian Harm Reduction Association (EHRA), and VOLNA members are also members of the Eurasian Network of People who Use Drugs (ENPUD). However, while these partnerships have produced joint statements and position

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17. Draft law 5715 [https://w1.c1.rada.gov.ua/pls/zweb2/webproc4\\_1?pf3511=72374](https://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=72374)  
and alternative draft law 5715-1 [https://w1.c1.rada.gov.ua/pls/zweb2/webproc4\\_1?pf3511=72484](https://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=72484)

papers, they have lacked activities to support drug user-led organisations at a national level. These activities in particular include those aimed to strengthen organisational development, provide training to advance capacity, enhance knowledge and skills among the community of people who use drugs, as well as to strengthen national advocacy. In addition, communication is not always well coordinated and focuses primarily on key international events that, while important, have little impact on the daily lives of people who use drugs in Ukraine.

**At the global level:** VOLNA, together with ENPUD and Ukrainian Network of Women who Use Drugs (VONA), has also partnered with the International Network of People who Use Drugs (INPUD) in the midst of the full-scale invasion launched by the Russian Federation in Ukraine in 2022. This partnership successfully advocated for the Global Fund to divert funding to support the establishment of temporary and rapid measures to restore access to critical health services and mitigate the risk of treatment disruption for people who use drugs. These measures include providing take-home OAT, advocating that national law enforcement and territorial defence units ensure that people who use drugs in possession of OAT were not detained, providing evacuation service to people who use drugs on OAT from the occupied territories to areas where treatment is available, and distributing needles and syringes to people who use drugs in bomb shelters.

**Lessons learned:**

To achieve the change we want, it is necessary to consider the interests of other partners, donors, and other stakeholders who, in one way or another, seek to support the community of people who use drugs.

In considering what partnerships should work on in the future, VOLNA believes that there is a need to convince donors to start really believing in people who use drugs and other key population communities' ability to implement programmes. In particular, there is a need for them to understand that they require different and more appropriate approaches to funding grassroots communities in ways that do not place unrealistic expectations and burden on community-led organisations and networks. Such a change is necessary if key population communities are to really benefit, and resources are to be dispersed equitably. To illustrate current inequity: a person in Ukraine will not receive services without documents, but there is no allocation of resources by the donor to obtain or restore the documents of the targeted community, and so fewer people than expected are only able to access the services. Even though this results in savings, the savings from the grant are not permitted to be used to restore the person's documents. They can only be reprogrammed into other elements of the national programme that do not meet the needs of the community of people who use drugs.

A second lesson from the experience of VOLNA is to assume nothing and avoid jumping to conclusions – listen, reflect on what you hear from all stakeholders, and analyse their perspectives before arriving at a conclusion about how to proceed or respond.

Thirdly, VOLNA advises to strengthen your network of partnerships that go beyond making loud joint statements, in order to increase the scope and reach of joint activities.

Finally, it is important not to ignore strategic organisational development needs, which are critical to sustainable drug user-led organisations and organising.

The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs.

INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs and its impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national, and regional levels.

INPUD sincerely thanks the regional and national networks that provided their thoughtful input and shared their invaluable experience on good, bad and ugly partnerships.



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*Written by:* Ruth Morgan Thomas

*With contributions from:* Judy Chang and Aditia Taslim

*Proofreading:* Zana Fauzi

*Designed by:* Mike Stonelake

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INPUD Secretariat  
23 London Road  
Downham Market  
Norfolk, PE38 9BJ  
United Kingdom

**[www.inpud.net](http://www.inpud.net)**