

The lost decade:

Neglect for harm reduction
funding and the health crisis
among people who use drugs

JULY 2018

Catherine Cook & Charlotte Davies



HARM REDUCTION
INTERNATIONAL

www.hri.global

The lost decade: Neglect for harm reduction funding and the health crisis among people who use drugs

Catherine Cook & Charlotte Davies

© Harm Reduction International, 2018
ISBN 978-0-9935434-6-3

Copy-edited by Michael Parsons

Research and analysis for this report was undertaken by Charlotte Davies, Professor Vivian Hope and Professor Marie-Claire van Hout of the Public Health Institute, Liverpool John Moores University, UK with support from HRI.

Designed by Corinne Welch

Published by
Harm Reduction International
61 Mansell Street
Aldgate
London
E1 8AN
United Kingdom

Harm Reduction International

is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights-based approaches to drug policy through an integrated programme of research, analysis, advocacy and partnerships. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights. The organisation is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

Acknowledgements:

Harm Reduction International would like to thank Charlotte Davies, Professor Vivian Hope and Professor Marie-Claire van Hout, of the Public Health Institute at the Liverpool John Moores University in the UK for the research and analysis on harm reduction funding in low- and middle-income countries that informed this report.

The authors would like to thank Olga Szubert, Fionnuala Murphy, Naomi Burke-Shyne, Edward Fox, Emily Rowe and all colleagues at Harm Reduction International for their support and assistance in the development of this report.

Harm Reduction International would also like to acknowledge and thank representatives within harm reduction donors, agencies and civil society organisations that shared information and insights on harm reduction investments: David Traynor and Mauro Guarinieri at the Global Fund for AIDS, Tuberculosis and Malaria; Billy Pick and Erin Eckhart at PEPFAR; Fariba Soltani at UNODC; Jose-Antonio Izazola Licea at UNAIDS; Caterina Gironda at Funders Concerned about AIDS; Joseph Dieleman at the Institute for Health Metrics and Evaluation, University of Washington; Monique Middlehoff at Netherlands MoFA; Daniel Wolfe at Open Society Foundations; Matt Blinstrubas at Elton John AIDS Foundation, US; Thomas Brigden at Elton John AIDS Foundation, UK; Stephanie Combes at the Bill & Melinda Gates Foundation; Laura D'Arrigo at the Ministry of Health, Government of France; Sally Chakawhata at the UK Department for International Development; Pia Engstrand at SIDA, Government of Sweden; Daniella Fanarof at Population Services International; Johannah Davis at the International HIV/AIDS Alliance; Wessam El Beih at the DROSOS Foundation; Elena Zaytseva at Open Health Institute; and, Shaun Shelly at the TB/HIV Care Association.

The authors would especially like to give thanks to Daniel Wolfe, Jamie Bridge, Susie McLean, Professor Vivian Hope, Ganna Dovbakh, Chris Abuor, Bernice Auma Apondi, Mathilde Laval, Ma Thu Thuy and Maria Phelan for providing valuable insights and feedback, and for reviewing sections of the report.

This report was made possible by financial contributions from the Robert Carr civil society Networks Fund and the Elton John AIDS Foundation.



Contents

List of tables.....	4
List of figures.....	4
Acronyms and Abbreviations.....	4
Executive Summary.....	5
1. Harm reduction funding in low- and middle-income countries.....	7
1.1 Introduction.....	8
1.2 The current state of harm reduction funding in low- and middle-income countries.....	9
1.2.1 Where are harm reduction funds going?.....	11
1.2.2 The wider funding environment.....	14
2. International donor funding for harm reduction.....	17
2.1 An overview of international donor support for harm reduction.....	18
2.1.1 Which donors are funding harm reduction?.....	18
2.1.2 Where are international donors funding harm reduction?.....	19
2.1.3 What harm reduction interventions are funded by international donors?.....	22
2.1.4 The crucial role of international donors in funding harm reduction advocacy.....	23
2.2 The Global Fund to Fight AIDS, Tuberculosis and Malaria.....	24
2.2.1 How much does the Global Fund invest in harm reduction?.....	25
2.2.2 Global Fund harm reduction investments over time.....	26
2.2.3 A harm reduction lens on Global Fund allocation, eligibility and transition.....	32
2.3 Bilateral funding for harm reduction.....	36
2.3.1 PEPFAR.....	36
2.3.2 How much does PEPFAR invest in harm reduction?.....	37
2.3.3 Other bilateral funding for harm reduction.....	40
2.4 Philanthropic funding for harm reduction.....	43
3. Domestic funding of harm reduction.....	45
Methodology.....	51
References.....	53

List of tables

Table 1: International donor funding for harm reduction in 2016	19
Table 2: Top 10 beneficiary countries of international donor harm reduction funding in 2016.....	20
Table 3: Pledges to the Global Fund during the four rounds between 2001 and 2016	28
Table 4: Harm reduction data for countries with Global Fund harm reduction allocations between 2002-2016 but ineligible for HIV country grants on 2017 or 2018 eligibility lists	28
Table 5: Available data, sources and uncertainties identified on domestic harm reduction investment in countries with over 100,000 people who inject drugs.....	47

List of figures

Figure a: Share of people who inject drugs in LMICs & Share of identified harm reduction spending in LMICs.....	13
Figure b: Proportion of harm reduction funding and people who inject drugs by region.....	14
Figure c: Percentage of international donor harm reduction funding by region.....	20
Figure d: Proportion of international donor funding and people who inject drugs by country-income status.....	20
Figure e: Global Fund rounds-based allocations to harm reduction 2003-2016 (US\$ 2016 prices).....	27
Figure f: Proportion of country grants allocated to each region under rounds-based funding (2002-2014) and allocation model funding (2014-2016).....	30
Figure g: Percentage of HIV spending from government alongside percentage of prevention spending from government.....	49

Maps

Map 1: Variation in harm reduction funding levels in LMICs assessed as the number of cents per day per person injecting drugs	12
Map 2: Countries that received harm reduction support through Global Fund rounds-based funding (2002-2014) and allocation model funding (2014-2016).....	31

Acronyms and Abbreviations

CAHR – Community Action on Harm Reduction	MoFA – Ministry of Foreign Affairs of the Netherlands
COPs – Country Operational Plans	NASA – National Aids Spending Assessment
EECA – Eastern Europe and Central Asia	NSPs – Needle and syringe programmes
EJAF – Elton John AIDS Foundation	OSF – Open Society Foundations
FCAA – Funders Concerned about AIDS	OST – Opioid substitution therapy
Gates Foundation – Bill & Melinda Gates Foundation	PEPFAR – President’s Emergency Plan for AIDS Relief
Global Fund – Global Fund for AIDS, Tuberculosis and Malaria	PITCH – Partnership to Inspire, Transform and Connect the HIV response
HRI – Harm Reduction International	RCNF – Robert Carr civil society Networks Fund
IHAA – International HIV/AIDS Alliance	SDGs – Sustainable Development Goals
IHRD – International Harm Reduction Development Program (Open Society Foundations)	UNAIDS – Joint United Nations Programme on HIV/AIDS
LMICs – Low- and middle-income countries	UNFPA – United Nations Population Fund
MAT – Medication Assisted Therapy	UNODC – United Nations Office on Drugs and Crime
MENA – Middle East and North Africa	

Executive Summary

In Harm Reduction International’s 2010 report on the state of global funding for harm reduction, we stressed, ‘more money is needed for harm reduction, and it is needed now’. Sadly, this statement remains true in 2018.

Harm reduction interventions for people who use drugs—such as needle and syringe programmes (NSP) and opioid substitution therapy (OST)—are cost-effective, protect against HIV and hepatitis C, and save lives. Despite the potential for these interventions to contribute to healthier communities, funding for harm reduction in low- and middle-income countries (LMICs) has flat-lined over the past decade. In 2016, US\$188 million was allocated – the same amount as in 2007 and just 13% of the US\$1.5 billion that UNAIDS estimates is required for an effective response in LMICs.

Beneath this enormous funding shortfall are disturbing trends. International donor funding, which comprises the majority of harm reduction funding in LMICs, is declining. Donor governments are withdrawing direct funding to countries for harm reduction on the basis that it is being channelled through multilateral institutions like the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Yet, Global Fund support for harm reduction may be decreasing, with data suggesting allocations in 2016 are 18% lower than those in 2011. Simply put, the lives of people who use drugs are being neglected.

The consequences of this donor retreat cannot be overstated. People who inject drugs are among the most vulnerable to contracting blood-borne viruses. New HIV infections among this population increased by one third from 2011-15, and HIV epidemics among people who inject drugs are commonplace in Asia and Eastern Europe. Harm reduction is integral to the world’s HIV response and cannot be ignored. This is particularly true in upper-middle income countries where the majority of the world’s 11 million people who inject drugs live.

Harm reduction is integral to the world’s HIV response and cannot be ignored.

In the face of donor withdrawal for harm reduction the onus is shifting to national governments. There are select bright spots where LMIC governments are working to protect people who use drugs through a scale-up in funding. But more needs to be done and, in environments where people who use drugs are criminalised and excluded, these gains are fragile at best. As Harm Reduction International’s research has detailed in the past, an initial step to meet the funding needs would be redirecting a small portion of the considerable resources spent on drug control to harm reduction interventions. Our modelling shows that a 7.5% shift in resources could bring about a 94% drop in new HIV infections among people who inject drugs by 2030.

This is not to say that international donors can wash their hands of the issue. Collectively, they must increase their support for harm reduction – particularly for priority interventions like NSP and OST – to fill the sizeable funding gap. Any transition from international to domestic funding has to be gradual with a concrete plan in place to ensure that donor withdrawal doesn’t result in the cut off of harm reduction services.

It is important to acknowledge that because a majority of international donor funding for harm reduction comes from the HIV sector, this report necessarily tackles select harm reduction interventions focused on injecting drug use. In reality, harm reduction is far broader than

this. It covers a range of substances, overdose prevention, and wider healthcare and social interventions for people who use drugs. Fundamentally, it is about meeting people where they are at in their lives without judgement. When governments invest in this strategy beyond the lens of HIV prevention, the public health and social impact for individuals, families and communities will be significant.

With the global HIV response now operating against the backdrop of the 2015 Sustainable Development Goals (SDGs), including the aim to end AIDS by 2030 and 'leave no one behind', the expectation has never been so great. Unless the funding landscape for harm reduction changes urgently, this goal will come and go as others have and the pledge to leave no one behind will ring hollow. People who use drugs are being forgotten - with dire public health and social consequences. This report demands donors act urgently to address the lost decade in funding for harm reduction and prevent an escalation of the current health crisis.

Recommendations:

The below are high-level recommendations from the report. More detailed recommendations for international donors and governments are included throughout.

- International donors must increase harm reduction funding in line with epidemiological need and not withdraw or reduce funds without adequate transition plans in place.
- Donor governments must fund harm reduction bilaterally and not rely solely on contributions to multilaterals and the UN to meet harm reduction commitments.
- Philanthropic donors must increase their support for harm reduction, and leverage their position as funders to call for other philanthropic, national and multilateral donors to increase their commitments to harm reduction.
- International donors, including donor governments, must ensure full replenishment for the Global Fund and the Robert Carr civil society Networks Fund, and ensure that the Joint UN Programme on HIV/AIDS (in particular UNODC as the lead agency on HIV and drugs) is sufficiently funded to achieve the Fast Track Strategy to end AIDS by 2030.
- The Global Fund should increase its harm reduction funding and ensure funds are directed to countries with the greatest need, regardless of income status.
- PEPFAR should increase harm reduction funding and ensure funds are used for priority interventions, such as needle and syringe programmes and opioid substitution therapy.
- National governments should invest in their own harm reduction responses. They should critically evaluate their drug policy spending and redirect resources from ineffective drug law enforcement to harm reduction.

1. Harm reduction funding in low- and middle-income countries

1. Harm reduction funding in low- and middle-income countries

1.1 Introduction

Harm reduction aims to reduce the health, social and economic harms associated with drug use, without requiring people to stop using drugs.^[1] It is an approach underpinned by the principles of pragmatism, dignity, human rights and public health, and one within which people who use drugs are firmly at the centre.

Over the past decade, Harm Reduction International (HRI) has documented a slow and steady increase in countries adopting harm reduction. In 2016, 90 countries were implementing needle and syringe programmes (NSPs) to some degree and 80 had at least one opioid substitution programme (OST) in place.^[2]

However, only one-hundredth of the world's people who inject drugs live in countries where these two lifesaving harm reduction measures are widely available.^[3] In most low- and middle-income countries (LMICs) programmes remain small-scale and lack the financial and political support necessary to meet national need.

In LMICs, a small number of governments have provided domestic support for harm reduction; however, the majority of funding has come from international donors. Funds have almost always been provided from budgets for key population programmes as part of the international HIV response, with the effect that harm reduction interventions not seen as central to addressing the HIV epidemic have been neglected, such as, overdose prevention, the response to viral hepatitis, or harm reduction for non-injecting drug use.

Donor funds have been crucial to turning HIV epidemics around in many countries and have saved countless lives. Harm reduction programmes in countries such as Vietnam and Ukraine have been credited with dramatic reductions in new HIV infections among people who inject drugs. These successes demonstrate the potential impact of harm reduction when adequately supported and resourced.

Throughout this report, we use the phrase 'people who inject drugs' where we are referring to specific data or circumstances. We otherwise default to the broader, more inclusive framing of 'people who use drugs'.

1.2 The current state of harm reduction funding in low- and middle-income countries

Since 2007 when HRI commenced research on this issue, harm reduction funding has fallen short of every published estimate of need for addressing HIV among people who inject drugs. In 2016, it is estimated that US\$188 million was allocated to harm reduction in LMICs, equating to just 13% of the US\$1.5 billion that the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates is required annually by 2020 for an effective response.

In 2016, it is estimated that US\$188 million was allocated to harm reduction in LMICs, equating to just 13% of the estimated US\$1.5 billion required for an effective response.

What resources are needed for harm reduction in low- and middle-income countries?

In 2011, UNAIDS released the Strategic Investment Framework, which included an annual needs estimate of US\$2.3 billion for HIV prevention, treatment and care for people who inject drugs in LMICs to be achieved by 2015.^[4]

In 2015, UNAIDS estimated that US\$26.2 billion annual investment was needed by 2020 to fund their Fast Track Strategy to End AIDS by 2030.^[5] UNAIDS published a resource needs estimate of US\$1.5 billion annually by 2020 to reach 90% of people who inject drugs with harm reduction services^{1, [6]}

In 2016, Harm Reduction International's 'The Case for a Harm Reduction Decade' report undertook mathematical modelling to illustrate the potential of redirecting a small percentage of spending on drug control to harm reduction. Redirecting just 7.5% of drug control spending globally (US\$7.5 billion) would bring high coverage² for harm reduction. By 2030, the results of this would be staggering, enabling us to cut new HIV infections among people who inject drugs by 94% and reduce HIV-related death by similar proportions.^[7]

There are differences in the methods and parameters used to reach these estimates of resource need. But whichever is used, it is clear that the current level of harm reduction funding is desperately low in comparison to estimated need. For each year that we remain so far off target, we allow HIV and viral hepatitis epidemics to increase and, as a result, the resources needed to end AIDS will also grow.

1. The estimate included OST and 'PWID outreach'.

2. UN guidelines consider coverage of 40% for OST and 60% for NSP to be high.

Perhaps most striking of all is the finding that there has been no increase in harm reduction funding since 2007, when US\$160 million (US\$187 million in 2016 prices) was estimated to have been spent on harm reduction.^[8] This is despite the UN target of halving HIV transmission among people who inject drugs by 2015. This target was spectacularly missed, with UNAIDS reporting new HIV infections had, in fact, increased by 33% between 2011 and 2015.^[9] It is also despite the

There has been no increase in harm reduction funding since 2007

indisputable evidence that harm reduction works, saves money and saves lives. It is frustrating to find that many of the recommendations and calls to action made in our previous reports on harm reduction funding need to be repeated here.^{[8] [10]}

The challenges in estimating harm reduction investment

Assessing the amount invested in harm reduction is extremely challenging. Information is not systematically collected in a way that is conducive to isolating harm reduction spend, or is not made public by governments or donors. Funders are often only able to identify allocations rather than actual expenditure, which is problematic as these can be quite different. Donors and governments use different categories to record funding information, with the result being a lack of clarity on the harm reduction activities funded and an inability to meaningfully compare spend across providers.

For this study, Harm Reduction International gathered the best possible data on harm reduction investments in LMICs, from a range of sources. In surveying international donors, we attempted to capture funds going towards the delivery of the UN-recommended package of interventions, as well as related training/capacity building, research and advocacy. We also requested geographical and programmatic detail for harm reduction investments and specifically asked about funds for neglected areas of harm reduction programming, such as overdose prevention, prisons and harm reduction for stimulant use (e.g., amphetamine-type stimulants or cocaine). When assessing domestic investment, secondary data was gathered from a range of sources. The year of funding information and quality of data gathered varied considerably.

The great variability in the information gathered means there are numerous caveats and limitations attached to the data in this report. These issues highlight the drastic need for improvements in accuracy of recording harm reduction investment and ease of access to this information. However, even allowing for these caveats, the conclusion that harm reduction is dramatically underfunded remains unquestionably clear.

Current high-level goals and commitments related to harm reduction funding

In 2015, world leaders adopted the Sustainable Development Goals (SDGs), which include a target to end AIDS and combat hepatitis C by 2030, strengthen the prevention and treatment of drug use, and to achieve universal health coverage. Central to all SDGs is a commitment to 'leave no one behind'.^[11]

Also in 2015, UNAIDS adopted its 2016-2021 Strategy 'On the Fast Track Strategy to End AIDS' that includes an ambitious set of targets. Most relevant for harm reduction is the target that 90% of key populations, including people who inject drugs,³ have access to HIV combination prevention services by 2020.^[5]

The commitment to end AIDS and achieve Fast-Track targets was reaffirmed by member states in the 2016 UN Political Declaration on HIV and AIDS. Most significant for harm reduction was the commitment to a 75% reduction in new adult HIV infections to less than 500,000 annually by 2020. In order to reach the ambitious targets, member states committed to increasing and fully funding the AIDS response from all sources, including from innovative financing, and reaching overall financial investments in LMICs of at least US\$26.2 billion annually by 2020, with a continued increase from the current levels of domestic public and private sources.^[12]

Member states also noted with alarm the slow progress in reducing new HIV infections and the limited scale of combination prevention programmes, especially among key populations, and committed to ensuring that financial resources for prevention are adequate and constitute no less than a quarter of AIDS spending globally on average.^[12]

In order to mobilise resources for HIV prevention, UNAIDS, the United Nations Population Fund (UNFPA) and partners adopted the HIV Prevention Road Map in October 2017. The Road Map is based on five prevention pillars, the second of which is 'combination prevention programmes for all key populations' and explicitly includes harm reduction services for people who use drugs. The Road Map is relevant for all LMICs, but it focuses on 25 countries with high numbers of new infections in adolescents and adults in 2016.^[13]

1.2.1 Where are harm reduction funds going?

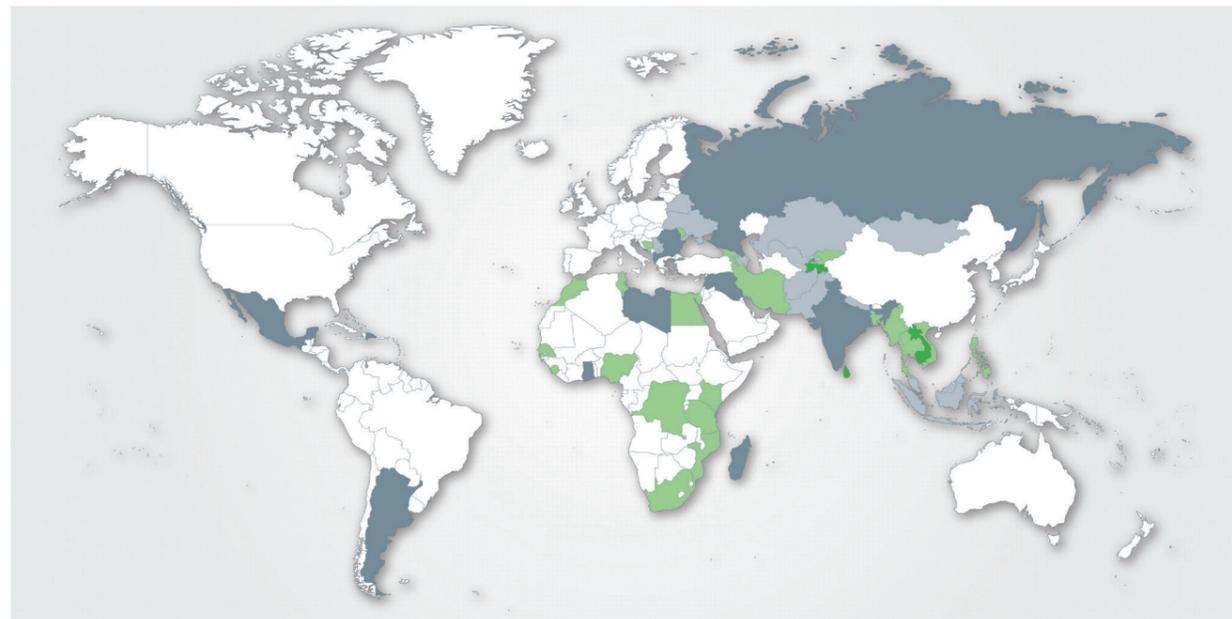
Harm reduction funding in LMICs in 2016 equated to just four cents per day for every person injecting drugs.⁴ This differs hugely by country, ranging from less than one cent per day in six countries to over a dollar a day in four countries. Russia accounts for 20% of people who inject drugs in LMICs but only 1% of identified harm reduction spending.

Harm reduction funding in LMICs in 2016 equated to just four cents per day for every person injecting drugs.

3. The others are: sex workers, men who have sex with men, transgender people, prisoners, and migrants

4. This has been calculated using population size estimates of people who inject drugs and harm reduction funding at a country level and summing for a total for low- and middle-income countries (LMICs). All LMICs included in this study that had population size estimates were part of the analysis. Size estimations were taken from a number of sources; Global State of Harm Reduction (2016 and 2018 pre-published data), Degenhardt et al. and UNODC's World Drug Report. Where an estimate was not available for a country, it was excluded from the analysis.

Map 1: Variation in harm reduction funding levels in LMICs assessed as the number of cents per day per person injecting drugs⁵



- | | | | |
|---|---|---|--|
| < 4 cents | 4 - 10 cents | 10 cents - US\$1 | > US\$1 |
| <ul style="list-style-type: none"> • Albania • Argentina • Ghana • Iraq • Libya • Macedonia • Maldives • Syria • Lebanon • Russian Federation • Mexico • Bulgaria • Dominican Republic • Madagascar • India • Romania | <ul style="list-style-type: none"> • Mongolia • Belarus • Afghanistan • Pakistan • Uzbekistan • Azerbaijan • Nepal • Kosovo • Ukraine • Kazakhstan • Malaysia • Serbia • Indonesia | <ul style="list-style-type: none"> • Thailand • Moldova • Congo (Democratic Republic) • South Africa • Iran • Armenia • Tunisia • Sierra Leone • Philippines • Tanzania • Egypt • Bosnia & Herzegovina • Mozambique • Vietnam • Kyrgyzstan • Georgia • Bangladesh • Mauritius • Myanmar • Nigeria • Kenya • Senegal | <ul style="list-style-type: none"> • Lao PDR • Cambodia • Tajikistan • Sri Lanka |

5. As spend data for China was only from one province and the population size estimate of people who inject drugs in Brazil is considered a vast overestimate, these two countries are excluded from this map so as not to misrepresent the situation.

Our research showed that the distribution of funds was not aligned with epidemiological evidence. Worryingly, upper middle-income countries have the largest share of people who inject drugs, but lower middle-income countries have the greatest share of harm reduction funding. China⁶ and Russia substantially shape this finding but it also reflects the predominance of international donors in the resourcing of harm reduction and their focus on low- and lower-middle income countries.

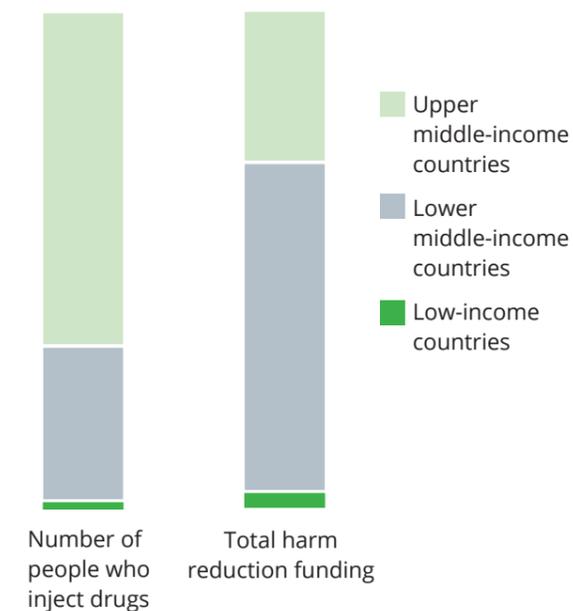


Figure a: Share of people who inject drugs in LMICs & Share of identified harm reduction spending in LMICs

6. Domestic investment data was only identified for Yunnan province in China, so a complete picture of spending in this country was not available.

7. While investment data was only identified for Yunnan province in China, it is safe to assume given the extent of programming in the country, national investment exceeds US\$1 million.

Harm reduction spending accounts for just 0.8% of all HIV spending in upper middle-income countries.

For both low- and lower middle-income countries, the average spend per person injecting drugs per day is around 9 cents, but that falls to 2 cents per day for the upper middle-income countries. Less than one-quarter of upper middle-income countries spend more than 10 cents a day.

Harm reduction spending accounts for just 0.8% of all HIV spending in upper middle-income countries. Despite international donors withdrawing from many upper middle-income countries, sizeable national government investment (over US\$1 million) has only been identified in a handful of these countries, namely China,⁷ Malaysia, Iran, Kazakhstan and Thailand.

Globally, the majority of harm reduction funding was for Asia and Eastern Europe, with Latin America accounting for a small proportion and Sub-Saharan Africa accounting for 16%. When compared with the share of the number of people who inject drugs, Latin America and Asia receive a smaller proportion of spend while Sub-Saharan Africa receives a greater proportion. Countries in the Middle East and North Africa (MENA) also receive a larger proportion of spend, but this reflects the relatively large harm reduction investment in Iran.



Figure b: Proportion of harm reduction funding and people who inject drugs by region

1.2.2 The wider funding environment

Harm reduction funding represented just 1% of the estimated US\$19.1 billion spent by donors and governments on the HIV response in 2016.^[14] Recent years have seen dramatic increases in domestic investment in some elements of national HIV responses, with latest figures indicating that states are now providing the majority share of HIV investment.^[14] However, most national governments have not prioritised harm reduction, or wider key population programming in their spending, even where the epidemic is concentrated among these groups. Of the US\$188 million funding for harm reduction in 2016, the majority (US\$120.7 million, 64%) was international donor funding. Very few countries have sufficient transparency of national expenditure data on harm reduction to identify the source and amount of domestic funding,

Harm reduction funding represented just 1% of the estimated US\$19.1 billion spent by donors and governments on the HIV response in 2016.

but in countries with available data, governments provided an average of one-quarter of harm reduction funding. By comparison, domestic resources accounted for 57% of HIV funding in LMICs.^[14]

International donor priorities have shifted in recent years, with most donors reducing aid to richer countries in favour of those with low income and high epidemic burden. In some countries,

Of the US\$188 million funding for harm reduction in 2016, the majority (US\$120.7 million, 64%) was international donor funding.

where government support is lacking, donor withdrawal has led to programme closures and rapid increases in HIV and hepatitis C among people who inject drugs, most notably in Central and Eastern Europe. There are fewer donors providing substantial specific funding for harm reduction now than a decade ago, while there has also been a significant decrease in bilateral aid for harm reduction and data suggest a decrease in Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) harm reduction allocations since 2011. All these factors combined are likely to have had most impact on harm reduction in upper middle-income countries, where the majority of people who inject drugs live.

UN agencies play an important role in providing guidance and technical support to governments, a factor which will be crucial for increasing domestic financial commitments to harm reduction. However, reductions in donor contributions to UNAIDS had a direct effect on

the agencies receiving funds to work on HIV/AIDS, including the United Nations Office on Drugs and Crime (UNODC), the lead UN agency on HIV and drugs. This resulted in a 50% reduction in core funding allocations to UNODC between 2015 and 2017.^[15] In 2017, member states adopted a Commission on Narcotic Drugs (CND) resolution which encourages member states and other donors to make extra-budgetary contributions to the HIV work of UNODC to secure adequately financed, targeted and sustainable responses related to HIV and drug use, and HIV in prison settings.

Broadly, however, it is projected that international donor funds for the HIV response are likely to reduce further in the future, with the emphasis moving towards health system strengthening and universal health coverage. Innovative financing and collaborations with the private sector also increasingly feature in funding strategies. The challenges for sustainable harm reduction funding within this shifting environment are formidable. Now more than ever, the tenacity and drive of the harm reduction movement is needed to sound the alarm. Governments, multilaterals and donors are failing people who use drugs. In 2010, we stated that 'funds are needed, and they are needed now'.^[8] In 2018, the same is true.

2. International donor funding for harm reduction

2. International donor funding for harm reduction

2.1 An overview of international donor support for harm reduction

International donors invested an estimated US\$121 million in 2016, accounting for 64% of all identified harm reduction funding. In 2007, HRI estimated donor investment to be US\$136 million.⁸ This difference represents a 24% decrease in real terms. In other words, harm reduction funding from international donors is one-quarter less than it was a decade ago.^[8]

Harm reduction funding from international donors is one-quarter less than it was a decade ago.

2.1.1 Which donors are funding harm reduction?

The Global Fund remains the main international donor for harm reduction, contributing two-thirds (US\$80.8 million) of all identified donor funding in 2016. Harm reduction is more reliant on the Global Fund now than it was a decade ago, when it provided one-third of all donor funds. During this time, bilateral funding has reduced considerably. The majority of donor governments that were providing bilateral harm reduction funding in 2007 now report that their support is predominantly channelled through multilateral organisations. Only 27% of donor funding for harm reduction was provided bilaterally compared to 79% of donor funding for HIV in 2016.^[16]

Between them, PEPFAR and the Global Fund provided 88% of all harm reduction donor funding in 2016.

The US government is an exception to this, providing US\$25.8 million of harm reduction funding to LMICs in 2016 through the President's Emergency Plan for AIDS Relief (PEPFAR), making it the second largest source of harm reduction funding. The Netherlands Ministry of Foreign Affairs (MoFA) was the only other donor government with harm reduction funds identified for 2016, amounting to US\$4.1 million.

Information was provided by 14 international donors (comprised of government, multilateral and philanthropic donors), 10 of which were able to identify harm reduction funding (Table 1). In 2007, there were eight donors that reported harm reduction investments of over US\$5 million,⁹ but in 2016, only two donors reported this level of investment: the Global Fund and PEPFAR. Between them, the two provided 88% of all harm reduction donor funding in 2016.

Table 1: International donor funding for harm reduction in 2016¹⁰

Donor	Funding identified for harm reduction in 2016 (in US\$ millions)	Source and notes
The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)	80.8 ¹¹	Survey response: harm reduction allocation for period 2014-2016 provided by Global Fund divided by 3 for 2016 estimate
President's Emergency Plan for AIDS Relief (PEPFAR)	25.8	Expenditure data from PEPFAR dashboards
International Harm Reduction Development (IHRD) Program, Open Society Foundations	4.9	Survey response
Netherlands Ministry of Foreign Affairs (MoFA)	4.1	Information provided through Netherlands MoFA
United Nations Office on Drugs and Crime (UNODC)	1.5	Survey response: health services only, adjusted for double counting with PEPFAR data
Robert Carr Civil Society Networks Fund (RCNF)	1.2	Survey response
International HIV/AIDS Alliance (IHAA)	1.0	Survey response: adjusted for double counting with Netherlands MoFA data
Elton John AIDS Foundation UK	1.0	Survey response
DROSOS Foundation (Switzerland)	0.3	Information on harm reduction specific projects provided by DROSOS Foundation
Elton John AIDS Foundation US	0.1	Survey response

2.1.2 Where are international donors funding harm reduction?

Regional perspective¹²

Thirty-seven per cent of identified donor funding went to Asia, with a slightly lower percentage (34%) going to Eastern Europe and Central Asia

(EECA). Around one-quarter (24%) was directed to Sub-Saharan Africa, with small percentages going towards MENA countries (2%), and countries in Latin America and the Caribbean (3%).¹³

8. This would be US\$159 million in 2016 terms.

9. In 2016 prices.

10. See methodology section for more information.

11. This amount represents one-third of allocations for harm reduction under new grants in the 2014-2016 period.

12. Regions are consistent with those used in HRI's Global State of Harm Reduction reports, with the exception that Latin America and the Caribbean are considered one region in this report.

13. Information on the country/region of funding was provided for US\$96.5 million of the international donor spend identified. For the remainder, funding was either global, for example for international networks or in the case of UNODC, it was not possible to determine how much was provided for individual countries/regions.

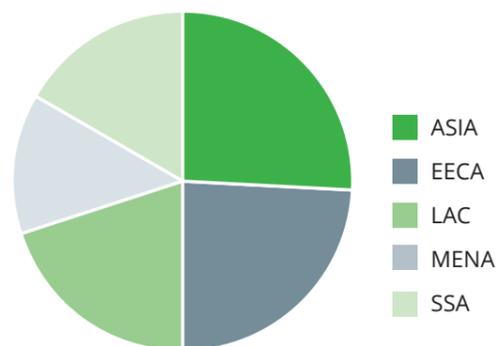


Figure c: Percentage of international donor harm reduction funding by region

Ukraine¹⁴ was the greatest beneficiary of international donor harm reduction funding in 2016, receiving US\$14.8 million and accounting for 15% of all identified funding and 42% of all EECA funding. Similarly, in 2016 Vietnam accounted for a third of the funding identified for Asia (35%) and the second largest share of international donor funding (14%). Only three other countries received over 5% of the total donor funding pot for harm reduction (Kenya, Nigeria and Myanmar; Table 2).

Table 2: Top 10 beneficiary countries of international donor harm reduction funding in 2016

Country	Funding (in US\$ millions)	% of total global funding*
Ukraine	14.8	15%
Vietnam	13.2	14%
Kenya	7.0	7%
Nigeria	6.9	7%
Myanmar	6.4	7%
South Africa	4.1	4%
Indonesia	3.9	4%
Georgia	2.9	3%
Pakistan	2.2	2%
India	2.1	2%

* total global funding where a beneficiary country is identified

Country income status perspective

The majority of international donor funding goes to lower middle-income countries, which receive 78 cents of every dollar spent. Despite the fact that two-thirds of people who inject drugs live in upper middle-income countries, only 17 cents in every dollar spent goes to these countries. International donors contribute just 3 cents per year towards harm reduction for each person injecting drugs in upper middle-income countries. This compares to 24 cents in lower middle-income countries and 32 cents in the low-income countries.

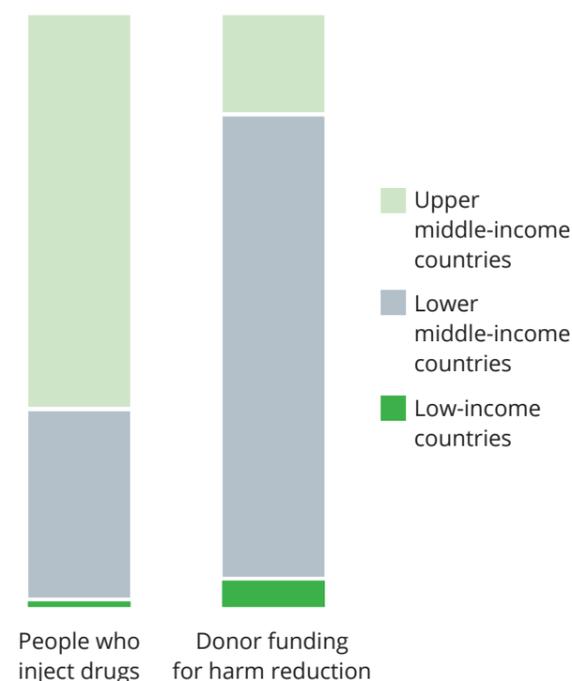


Figure d: Proportion of international donor funding and people who inject drugs by country-income status

14. The Global Fund allocation to Ukraine includes ARV treatment identified as going to people who inject drugs. Only one other country has this. It has been left in the analysis to make it consistent with previous funding estimates.

There are 11 LMICs reported to have more than 100,000 people who inject drugs¹⁵, seven of which are upper middle-income countries. Despite these seven countries being home to 5.6 million people who inject drugs, they were allocated a combined

total of only US\$4.4million of donor funding in 2016. This compares to US\$32.3 million in harm reduction donor funding provided to the other four countries – all lower middle-income – where 2.4 million people who inject drugs live.

Harm reduction funding in Kenya

Kenya has both a generalised HIV epidemic and a concentrated epidemic with prevalence among the general population of 6% and 18% among people who inject drugs.^[17] It is estimated that people who inject drugs account for 4% of new HIV infections annually, with about 30,000 people injecting in the country. The implementation of harm reduction interventions is a relatively new activity; between 2009 and 2012 only US\$0.08 million out of US\$496 million for prevention and US\$2,466 million for the HIV response was allocated to harm reduction programmes.^[18]

The United States Government invested US\$5.5 billion in Kenya's HIV response between 2004 and 2017. Investment in harm reduction services increased in 2013 when PEPFAR activities included the provision of a package of interventions for people who inject drugs in high burden areas, including opioid substitution treatment (OST).¹⁶

PEPFAR expenditure on OST increased from US\$0.9 million in 2014 to US\$2.7million in 2016 with a target of scaling-up coverage in three counties: Mombasa, Nairobi and Kalifi. A breakdown of PEPFAR expenditure shows that a sizeable proportion of the US\$2.7 million invested in OST during 2016 went to capacity building, with expenditure on health systems strengthening US\$0.5 million, training US\$0.15 million and construction and renovation US\$0.6 million. Similarly, health systems strengthening accounted for just over one-quarter (US\$0.6 million) of the US\$2 million expenditure on HIV prevention for people who inject drugs.

Funding of commodities for OST was covered predominantly by PEPFAR (91%) with only 9% coming from national sources.^[19] The 2017 Country Operational Plan, however, states that PEPFAR will not procure OST in 2018 although sites will be supported by mentorship, quality assurance and human resources.^[19] The Global Fund also provides financial support for harm reduction in Kenya, amounting to an estimated US\$1.6 million in 2016. The 2017 concept note for the Global Fund suggests that OST will now be partly supported by Global Fund money.

Funding was also provided in 2016 through the International HIV/AIDS Alliance and the Dutch Government's PITCH programme, as well as the DROSOS Foundation, while national funding remains low for harm reduction and prevention in general. This over reliance on uncertain donor

15. The 11 low- and middle-income countries are China, Russia, India, Brazil, Ukraine, Vietnam, Iran, Malaysia, Mexico, Kazakhstan and Pakistan. It should be noted that the population size estimate for people who inject drugs in Brazil is considered an overestimate, with recent unpublished research suggesting very few people inject drugs in the country. Removing Brazil from this list would not however, change the overall disparity.

16. PEPFAR use the term medication assisted treatment, or MAT. The package also included HIV testing, counselling and treatment, STI prevention and treatment, condom demonstration and distribution for people who inject drugs and their partners, targeted behavioural interventions and IEC materials, TB diagnosis and treatment and vaccination, and diagnosis and treatment of viral hepatitis.

Harm reduction funding in Kenya (continued)

support risks the sustainability of the response and leaves services in a precarious situation. The Kenya AIDS Strategic Framework (2014 to 2019) talks of a move from crisis management to strategic and sustainable mode, but highlights the fact that prevention is lagging behind in the national response.^[20]

In 2017, Kenya joined the Global HIV Prevention Coalition and committed to scaling up HIV prevention programmes, including among people who use drugs, in order to meet global and national targets to end AIDS by 2030. Funding for key populations prevention targets is estimated to increase by US\$4.1 million between 2016 and 2020, from US\$11.5 million to US\$15.5 million.^[21] However, it is not specified if the increased funding will be coming from domestic or international resources.

2.1.3 What harm reduction interventions are funded by international donors?

In 2016, the majority of the identified international donor funding for harm reduction was earmarked for the provision of health services and for capacity building. It was not possible to gather comprehensive data disaggregated by harm reduction intervention from most donors. As donor funding for harm reduction is almost always derived from HIV budgets, it follows that funding would be directed to the most effective interventions to prevent HIV among people who inject drugs: NSP and OST. However, the research found that both of the largest donors to harm reduction, the Global Fund and PEPFAR, had substantial grants in countries where these priority interventions were either not in place, or were very limited. Funds for NSP and OST together represented about one-third of Global Fund monies for harm reduction.

Most donors were not able to provide funding amounts for harm reduction interventions that may not be prioritised under HIV budgets, for example, funding for overdose prevention, hepatitis, harm reduction for stimulant use and harm reduction in prisons.

Overdose is one of the most common causes of death among people who inject drugs and are living with HIV. Despite being part of the UN-recommended package of interventions, peer distribution of naloxone remains very limited in LMICs and is likely to have received very little dedicated funding from donors in 2016. Over 80% of people who inject drugs who are HIV positive also have the hepatitis C virus.^[22] Treatment is available, but access remains limited for this population. Despite this, donors are not allocating substantial funds to this life-saving treatment and ensuring integration with harm reduction and HIV programmes in LMICs.

Similarly, while several donors indicated that funded programmes may be reaching people who use amphetamine-type stimulants, most stated that they were not the main target of interventions. The only donor who explicitly noted their financial support for harm reduction services targeting non-injecting stimulant users in 2016 was OSF.¹⁷ UNODC, the Global Fund and PEPFAR reported funding for harm reduction in prisons.¹⁸ While UNODC was not able to estimate the extent

of this funding, for the Global Fund and PEPFAR it was indicated that this represented minimal proportions of overall harm reduction funding.

This overall picture is somewhat inevitable given that almost all harm reduction funding stems from HIV budgets, but it does raise an important concern. Harm reduction has applicability beyond

HIV prevention, in reducing health, social and economic harms that can be related to drug use and in improving the quality of life for people who use drugs. In short, we need to look beyond HIV donors to fund harm reduction.

2.1.4 The crucial role of international donors in funding harm reduction advocacy

In 2016, of 158 countries and territories where injecting drug use has been reported, 68 still have no NSP, and 78 have no provision of OST.^[22] The harm reduction funding crisis remains a crisis of political support for harm reduction in many countries. Gains made in increased domestic investment in harm reduction are far from proportionate to the gains made in domestic investment in HIV programmes overall. The responsibility is with exiting donors, UN agencies and crucially, civil society organisations to call on governments and support them to step up and fund these life-saving programmes. Strong advocacy requires secure and sustained funding for civil society, including networks of people who use drugs, but this is rarely prioritised in domestic funding. International donors have a crucial role, now more than ever, in funding harm reduction advocacy.

Funding for advocacy, human rights work and policy reform was estimated to be US\$9.8 million, representing 8% of all international donor funding for harm reduction. OSF invested 75% of its total expenditure for harm reduction on advocacy work in 2016, equating to US\$4.2 million, the largest amount identified. Of OSF's total expenditure, 26% went to Latin American and Caribbean countries, principally Brazil and Colombia. This is in contrast to overall donor expenditure where very little went to these countries (2.5% overall, including OSF's contribution).

Robert Carr civil society Networks Fund (RCNF), an important pooled funding mechanism dependent on replenishment from donors, also primarily funds advocacy work, with US\$1.2 million worth of harm reduction funding identified in 2016. Around half of this goes to the Harm Reduction Consortium, which was funded by the UK's Department for International Development (DFID) between 2006 and 2012, but has since been supported by core funding from RCNF. All three of the main consortia funded - the Harm Reduction Consortium, the INPUD-ANPUD Consortium and Eurasian Regional Consortium - have been awarded lower funding amounts in 2018.

In 2016, it is estimated that 3% of Global Fund money was allocated to advocacy, amounting to US\$2.6 million.

Other donors such as PEPFAR support advocacy work, but it has not been possible to identify the amount of funding. Some information is contained in PEPFAR Country Operation Plans, showing that there is funding for advocacy and policy work, for example in Central Asia.

Elton John AIDS Foundation (EJAF) in the UK and US identify a small amount of funding going towards policy and advocacy work, representing 5% and 10% of their total expenditure, respectively. EJAF UK states that it expects to increase funding for HIV and harm reduction advocacy in Eastern Europe and Central Asia, with a new grants strategy to be released in 2018.

17. In 2017/18, the German Government has supported exploratory research and policy activities on harm reduction for stimulant use. There may have been some funds supporting this work in 2016 (the focus year of this study) however, it was not possible to obtain financial information from the donor.

18. This information was reported to HRI in survey responses.

While the above comprise identified funds supporting advocacy activities of civil society and networks, it is important to acknowledge the role of UN staff, particularly within UNODC, but also WHO and UNAIDS, in advocating for harm reduction approaches in LMICs.¹⁹ The recent funding cuts to UNAIDS, therefore, also pose concerns for harm reduction advocacy.

Recommendations:

- International donors must increase their funding for harm reduction in LMICs in order to meet commitments to 'leave no one behind' and ensure that their funding for harm reduction is used for priority interventions which will have the most impact: NSP and OST.
- International donors, including donor governments, must ensure full replenishment for the Global Fund and the Robert Carr civil society Networks Fund, and ensure that the Joint UN Programme on HIV/AIDS (in particular UNODC as the lead agency on HIV and drugs) is sufficiently funded to achieve the Fast Track Strategy to end AIDS by 2030.
- International donors must have an adequate transition plan in place when withdrawing or decreasing funding for harm reduction. In the event that transition strategies are not successful,

contingency funds must be available to ensure there is no gap in harm reduction funding.

- In countries where donor withdrawal has resulted in a funding gap for harm reduction, international donors must reinstate funding or provide emergency funding options to ensure services continue to operate.
- More broadly, international donors should ensure financial support for overdose prevention, including naloxone, harm reduction in prisons, treatment for hepatitis C and harm reduction interventions for stimulant use.
- International donors must increase their funding for harm reduction and human rights advocacy at national, regional and international levels, including support for networks of people who use drugs. Civil society-led advocacy for harm reduction funding will be critical in supporting the transition from donor to domestic funding.
- Donor governments must not rely on contributions to multilaterals and the UN to meet their harm reduction commitments. Bilateral funding for harm reduction must be reinstated and targeted to the countries where it is most needed, regardless of country income status.

2.2 The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund, created in 2002 to fight three diseases, remains the leading international donor investing in harm reduction. At its peak in 2010, an estimated US\$135 million was allocated to harm reduction, representing around 10% of the total HIV and HIV/Tuberculosis commitment. That year, the Global Fund articulated its explicit support and endorsement for harm reduction approaches^[23] and used a mechanism called the 'MARPS reserve' to earmark funds for most-

at-risk-populations. A significant change to the funding model was announced in 2013, requiring allocations to be based on country income level and disease burden.^[24] In line with the UNAIDS Fast-Track Strategy to End AIDS by 2030 and donor trends, the Global Fund is slowly moving away from funding middle-income countries. During the 2017-2019 period, all upper middle-income countries and all lower middle-income countries with low or moderate disease burden are required

to build plans to transition from Global Fund to national government support.^[25] As three-quarters of all people who inject drugs live in middle-income countries (27% in lower middle-income and 55% in upper middle-income countries).

2.2.1 How much does the Global Fund invest in harm reduction?

Assessing the extent to which Global Fund monies go towards harm reduction programmes is extremely difficult. Past investigations have been one-off exercises rather than part of an ongoing, systematic process.^{20 [26]} Several factors limit a full understanding of the situation.

Firstly, all the exercises to date have used allocation rather than expenditure data, meaning that they represent intended, rather than actual investments.

Secondly, the estimated absorption rate for Global Fund grants is around 70%²¹ and has not been factored into this analysis, so we can assume that the data reported here over-estimate actual expenditure.

Thirdly, allocations are reported by funding period rather than by the year funds are allocated for. The move to a three-year allocation-based funding model and the different timings on applications for funding means that it has only been possible to identify harm reduction funding over the full three-year allocation period rather than for individual years. Therefore, annual funding has been estimated by simply dividing the three-year period total by three.²²

the potential of this funding approach to have a devastating impact on harm reduction and the goal to end AIDS by 2030 among people who inject drugs is a major concern.

At a country level, where possible, data have been cross-checked with key contacts within that country.

Over the 2014 to 2016 period, it is estimated that US\$240 million was allocated to harm reduction, around US\$80 million per year.

Two-thirds (67%) was earmarked for health interventions listed within the comprehensive package for people who use drugs,²³ while just under one-quarter (23%) was allocated for capacity building/training and 3% was allotted for advocacy. In terms of the key interventions, 13% of the harm reduction allocation was for OST and 21% was for NSP. Countries with the largest harm reduction allocations, in descending size order, were Ukraine, Vietnam, Myanmar, South Africa, Nigeria, Indonesia, Georgia, Pakistan, Tajikistan, Russian Federation and Moldova. However, expenditure data may look quite different to the allocation figures for some of these countries. In Nigeria, for example, US\$8 million allocated to harm reduction for the 2014-2016 period is likely to have ended up being redirected to more politically palatable HIV programming that will have little HIV prevention impact for people who use drugs.^[2]

20. However, internal efforts are now underway to assess key population investment, including for people who inject drugs and key performance indicators on this have been developed.

21. See Table 4.1 for difference between approved funding and disbursed funding: https://reliefweb.int/sites/reliefweb.int/files/resources/Full%20Report_1011.pdf

22. Matching allocations to years would require the extraction of detailed information from each grant. Implementation periods for the 2014-2016 grants vary and the majority ended December 2017 but it has not been possible to factor this into the analysis as grant start and end dates were not provided by the Global Fund.

23. This included funds for the following: comprehensive condom and lubricant programming, NSP, OST, overdose prevention and management, including naloxone, behavioural interventions, pre-exposure prophylaxis, HIV testing and counselling, HIV treatment and care, prevention and management of viral hepatitis, prevention and management of TB, prevention and management of mental health conditions, sexual and reproductive health interventions, including contraception, diagnosis and treatment of STIs, cervical screening.

Without country-level expenditure data disaggregated by intervention, it is not possible to say with any certainty what has been spent on harm reduction in a country, but there are some conclusions that can be drawn by cross-checking with our knowledge of existing service provision. Several countries with substantial harm reduction allocations from the Global Fund (the largest of which were for South Africa and Nigeria) have no, or very limited provision of NSP and OST. These are the most effective interventions to prevent HIV for people who inject drugs. It is expected

and right that a proportion of Global Fund allocations in these countries are for advocacy and policy reform, with a view to introducing and scaling up NSP and OST services. But the size of these grants suggests that these allocations are also for interventions that, while important, will not succeed alone in preventing HIV and viral hepatitis among people who inject drugs. The Global Fund must ensure that funds are allocated to priority interventions that will have the most impact on epidemics.

2.2.2 Global Fund harm reduction investments over time

It is important to assess Global Fund investments over time to see whether the change from the rounds-based funding model to the allocation model has had an impact on harm reduction funding. Figure e shows rounds-based Global Fund allocations for harm reduction by the year that the funding was intended for.²⁴ Harm reduction allocations increased steadily between 2003 and 2008, with bigger increases between 2008 and 2011. However, over the latter period the proportion of overall harm reduction funding that went to NSP and OST decreased slightly, and these interventions continued to account for a lower proportion of harm reduction funding than in the early years of the Global Fund's activity. It is between 2010 and 2011 that the impact of the key 2010 initiative – the MARPs Reserve, a dedicated pot of money for most-at-risk

populations – can be clearly seen. This influence, and to a lesser extent that of Round 2 and Round 9 grants with harm reduction components, continues into the 2014-2016 period. However, the impact of these grants is significantly decreased by 2016, with many countries having transitioned onto new grants under the allocation funding model.

Unfortunately, data on new grants agreed under the allocation model for 2014-2016 were not provided by the Global Fund in sufficient detail to enable analysis over time. As described earlier, it is estimated that within these new grants for 2014-2016, harm reduction allocations amounted to US\$80.8 million (an estimate reached by dividing the aggregate figure by three). This is marked separately on the graph opposite for guidance.

24. Analysis was carried out using data that informed Bridge et al (2016). Trend data are adjusted to 2016 prices using the Bureau for Labor Statistics CPI inflation data for January each year. See methodology for more details.

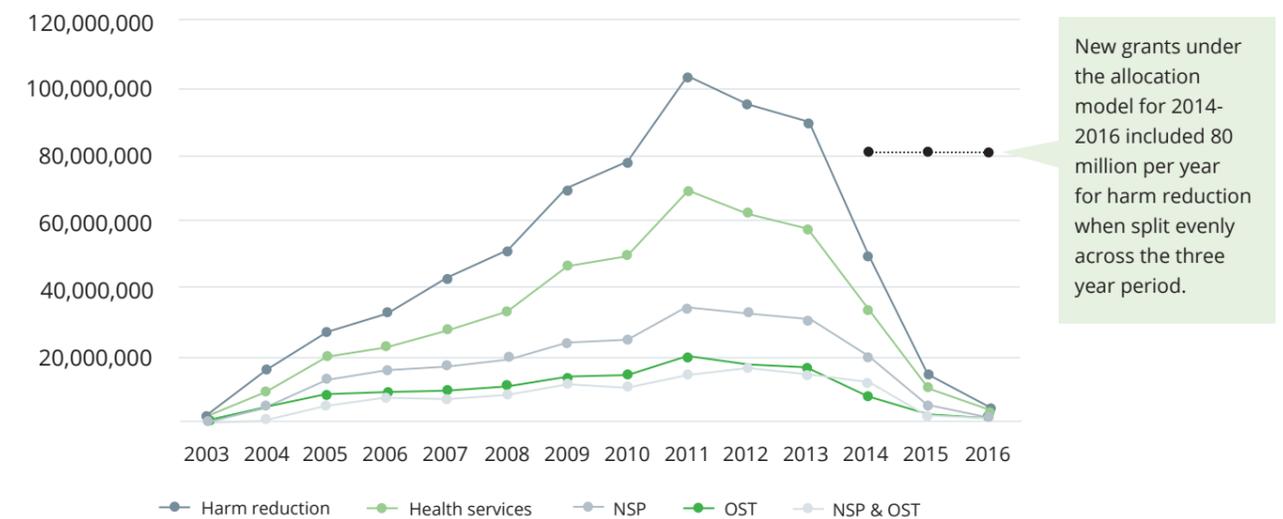


Figure e: Global fund rounds-based allocations to harm reduction 2003-2016 (US\$ 2016 prices)²⁵

This limits the extent to which we can assess the impact of the change in funding model for harm reduction. However, there is an indication that harm reduction funding under the allocation model may be less prioritised than under some of the previous funding rounds. When the US\$80.8 million estimate of per year funding is added to remaining rounds-based funding allocations for 2016, it suggests that harm reduction allocations for 2016 were 18% lower than that of 2011.²⁶ Further granularity on the new grants for 2014-2016 is urgently needed to provide a clear picture of yearly allocation trends (which may still differ significantly from actual expenditure data). For this, the Global Fund must improve the way in which they monitor and record their funding allocations and ultimately, expenditure on harm reduction. Pending this, with the information available to HRI for this research, we deemed this a safe conclusion based on the evidence to hand.

Global Fund allocations for harm reduction were 18% lower in 2016 than in 2011. This comes at a time when donor governments, such as the UK, have stopped bilateral harm reduction funding.

This represents an 18% reduction of Global Fund allocations for harm reduction at a time when individual donor governments, such as the UK, have ceased bilateral funding of harm reduction and state that their contributions are now channelled through multilaterals such as the Global Fund.²⁷ This cannot be attributed to a decrease in the Global Fund's overall budget, as between the 2008-2010 and 2014-2016 funding rounds, pledges to the Global Fund increased in nominal terms although they were stable taking inflation into account.²⁷

25. Data in this graph differ from the published data in Bridge et al. (2016) as they have been re-calculated for year of intended spend rather than year of allocation. Data for new grants in the 2014-2016 allocation period were provided in aggregated form rather than at grant level so it has not been possible to analyse funds by year of allocation, as for the rounds-based funding data.

26. For consistency and due to differences in the form of the data provided, the US\$80.8 million allocated under new grants for 2014-2016 is used in the calculations in the rest of the report.

27. US\$10,354,540,000 for 2008-2010 (2010 to 2016 prices)

Table 3: Pledges to the Global Fund during the four rounds between 2001 and 2016

2001 - 2007	2008 - 2010	2011 - 2013	2014 - 2016
9,187,430,331	9,381,162,826	9,543,457,752	10,427,725,858

Source: The Global Fund

Within rounds-based funding, harm reduction represented only 5% of the Global Fund's total investment in HIV. This has reduced further and within new grants allocated in 2014-2016, harm reduction accounted for 4% of HIV investments. If the percentage had remained stable, investment in harm reduction would have been US\$20 million (or 25%) higher in 2016.

The decline in funding for harm reduction by the Global Fund may reflect its changing funding eligibility criteria, which altered the geographical picture of the Global Fund's presence. Almost

one-quarter of the rounds-based harm reduction funding went to countries that did not receive a new grant in the 2014-2016 period. The focus has shifted to countries with low income and high disease burden and away from some of the countries with lower overall disease burden and higher income, but high need among people who inject drugs. Six of the 12 countries that previously received Global Fund funding, but are now listed as ineligible in either the 2017 or 2018 lists, have HIV prevalence rates among people who inject drugs of over 5% (see table 4).²⁸

Table 4: Harm reduction data for countries with Global Fund harm reduction allocations between 2002-2016 but ineligible for HIV country grants on 2017 or 2018 eligibility lists

Country	PWID population size estimate ^[2]	HIV prevalence among PWID	GF funding allocation 2014-2016	Reason for becoming ineligible	Eligibility to apply for transition funds, or under the NGO rule, ²⁹ or potential upcoming change in eligibility status
Albania	12,700	6.3	no	Low HIV disease burden	Eligible for transition funding 2017-2019
Algeria	nk	nk	yes	Moderate HIV disease burden	HIV disease burden went from moderate to high resulting in one determination of eligibility. ³⁰

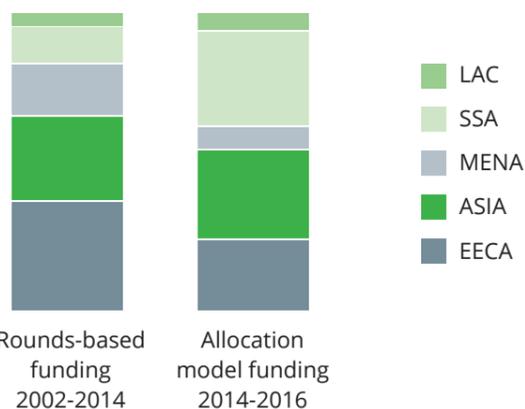
28. Algeria, Bulgaria, China, Estonia, Romania, Russia

29. The NGO Rule provides an exception to the OECD DAC rule, stating that in countries with high disease burden (for example, Russia, Bulgaria and Romania), civil society can access Global Fund support if there are 'political barriers' in the country. The term 'political barriers', however, is interpreted narrowly, as laws that criminalise provision of services. This interpretation enabled much needed funding in Russia in 2014-2018 on the basis of its legal prohibition of OST, amongst other factors, but does not capture Romania or Bulgaria. The political barriers criteria are assessed every three years in line with allocation cycle. For more information, see HRI's briefing on the impact of the Global Fund's eligibility policy on harm reduction at <https://www.hri.global/files/2018/05/01/HRI-Briefing-April-2018.pdf>

Argentina	65,829 (64,500-67,158)	3.5	no	G20 country	
Bosnia & Herzegovina	12,500 (9,500-15,500)	0.3	no	UMIC with low HIV burden	
Bulgaria	19,000	10.6	no	Not on OECD list of ODA recipients	NGO rule. Round 2 grant funds still being expended in 2017.
China	2,580,000	6	no	G20 country	
Croatia	10,000	0.48	no	UMIC with low HIV burden	
Estonia	13,801	50-60	no	High income country	
Macedonia	15,000-20,000	0.12	no	UMIC with low disease burden	Became ineligible in 2014, Round 10 grant funds still being expended in 2017.
Mexico	164,000	2.5	no	G20 country	
Romania	19,265	24.9	no	Not on OECD list of ODA recipients	NGO rule
Russian Federation	1,815,000	18-31	yes	Not on OECD list of ODA recipients	NGO rule. Change in income status from high to upper middle resulting in one determination of eligibility ³¹
Turkey	nk	0.2	no	UMIC with low disease burden	

30. Country components must be eligible for two consecutive eligibility determinations to be classified as eligible on the Eligibility List.

31. Country components under the NGO rule must be eligible for two consecutive eligibility determinations based on income classification and disease burden. The political barriers criteria required under the NGO rule are assessed every three years in line with the allocation cycle.



Source: Bridge et al. 2016; Global Fund

Figure f: Proportion of country grants allocated to each region under rounds-based funding (2002-2014) and allocation model funding (2014-2016)³²

Despite the different time periods covered, it is clear that there has been a move away from the Global Fund contributing to programmes in EECA and more focus on countries in Sub-Saharan Africa. In addition, countries in MENA are now less likely to be receiving Global Fund money (see Figure f and Map 2).

In the 2014-2016 allocation period, harm reduction accounted for 30% of HIV Global Fund allocations in EECA, 17% in MENA and 15% in Asia.

Global Fund data show that the countries with the five largest total HIV allocations in 2014-2016 were all Sub-Saharan African countries (South Africa, Nigeria, Kenya, Tanzania and the Democratic Republic of the Congo). Harm reduction accounts for only 1.9% of the overall HIV allocations across these countries and is as low as 0.1% in Tanzania. This corroborates findings from a recent study

showing that the proportion of prevention funding in Global Fund signed grant agreements in African countries fell well below the recommended 25% in 2014-2016 and that prevention across all key populations³³ accounted for less than 3%.^[28]

During the 2014-2016 allocation period, the Global Fund also made several multi-country and regional grants through its catalytic investment funding,³⁴ which had a harm reduction focus, including two in EECA, one in MENA, one in Asia, and three in Sub-Saharan Africa. Of these seven grants, five were solely harm reduction focused, collectively amounting to US\$31 million, from a total of US\$134 million for multi-country HIV grants. While most have not funded service provision,³⁵ these grants have provided a crucial opportunity to fund harm reduction advocacy and to focus on efforts to increase or establish domestic support. Multi-country grants also provide a mechanism for those countries ineligible for country grants on the basis of their income status, to access small amounts of funding (only 51% of countries in any multi-country application must meet the Global Fund's eligibility criteria).

However, the HIV multi-country funding allocation has now been reduced significantly and overall this will be US\$50 million for the 2017-2019 grant period. Multi-country grant opportunities will be available for four regions only: Latin America and the Caribbean, EECA, MENA and Asia. These grants will not have a sole focus on harm reduction but will instead be targeted towards key population programme sustainability more broadly.^[29] The current multi-country grants in Africa, which are advocacy-focused, will not be renewed when they expire.

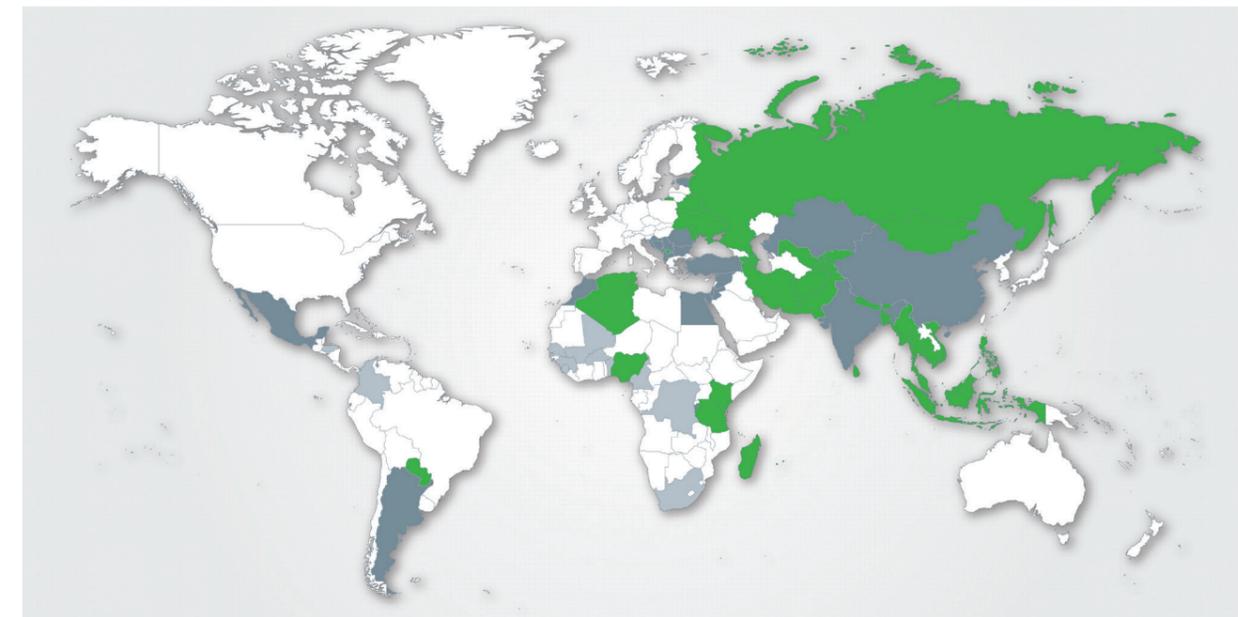
32. Note that the time periods differ so the number of countries should not be compared.

33. Men who have sex with men, transgender people, sex workers and people who inject drugs.

34. Catalytic investments are described as 'programs, activities and strategic investments that are not adequately accommodated through country allocations but that are essential to achieve the aims of the Global Fund Strategy 2017-2022 and global partner plans.' They include matching funds, multi-country initiatives and strategic investments. For more information, see <https://www.theglobalfund.org/en/funding-model/funding-process-steps/catalytic-investments/>

35. An exception to this was the MENA grant held by MENAHRA which included services as 'advocacy model projects'.

Map 2: Countries that received harm reduction support through Global Fund rounds-based funding (2002-2014) and allocation model funding (2014-2016)



- | Received rounds-based and allocation model funding | Received rounds-based funding only | Received allocation model funding only |
|---|--|---|
| <ul style="list-style-type: none"> • Afghanistan • Algeria • Armenia • Azerbaijan • Bangladesh • Belarus • Bhutan • Cambodia • Georgia • Indonesia • Iran • Kenya • Kosovo • Kyrgyzstan • Madagascar • Malaysia • Mauritius • Moldova • Mongolia • Myanmar • Nepal • Nigeria • Pakistan • Paraguay • Philippines • Russian Federation • Sri Lanka • Tajikistan • Thailand • Tunisia • Ukraine • Uzbekistan • Vietnam • Zanzibar | <ul style="list-style-type: none"> • Albania • Argentina • Bosnia & Herzegovina • Bulgaria • Burundi • Cape Verde • China • Croatia • Egypt • Estonia • India • Jordan • Kazakhstan • Macedonia • Maldives • Mexico • Montenegro • Morocco • Palestine • Romania • Serbia • Syria • Timor-Leste • Turkey | <ul style="list-style-type: none"> • Benin • Burkina Faso • Cameroon • Colombia • Congo (Democratic Republic) • Guinea • Honduras • Mali • Senegal • Sierra Leone • South Africa |

2.2.3 A harm reduction lens on Global Fund allocation, eligibility and transition

The two indicators now used to determine eligibility and to inform allocations for Global Fund funding are country income status and disease burden, with the underlying assumption that higher income countries should fund their own health responses. This has resulted in funding allocation reductions to middle-income countries, where most people who inject drugs live. Some countries are now ineligible for country grants or are included on the Global Fund list of countries that need to prepare for transition.^[30]

Several countries that have been heavily reliant on Global Fund allocations for harm reduction have seen dramatic reductions in their allocations for the period 2017-2019. For example, on a per-year basis, Moldova's 2017-2019 allocation represented a 43% drop from 2014-2016.^[31] It is telling that the Committee on Economic, Social and Cultural Rights (CESCR) recently raised concerns and included a call for the state to fund harm reduction in its concluding observations on the third periodic report of the Republic of Moldova: *'The Committee is concernedthat the harm reduction programmes for drug users face the withdrawal of international funding, which will result in fewer health services and an increased prevalence of hepatitis and HIV among drug users.'*^[32]

Unfortunately, country income status and disease burden among people who inject drugs are not predictive factors for a government funding its own harm reduction response. The use of disease burden as a measure may in itself deprioritise HIV prevention efforts for people who inject drugs, by not allowing countries to seek funding to prevent epidemics before they become considered high burden.

The challenges and complexities of transitioning from international donor funding to domestic financing are likely to be particularly pronounced for harm reduction. Governments often lack the political will to direct funding towards harm reduction and, even where it is present, they may lack technical expertise in harm reduction programming and/or mechanisms for social contracting necessary to fund civil society programmes. For some countries that became ineligible for HIV funding before a transition policy was developed, such as Romania^[33] and Serbia,^[34] the end of Global Fund grants led to programme closures and spikes in infections. Serbia subsequently became re-eligible for funds due to increases in disease burden.

These situations clearly illustrate the importance of long transition periods and the availability of emergency or 'bridge' funding to avoid service closures and public health threats when international donor funding ends and governments are not ready to plug the funding gap left behind.^[34]

Harm reduction funding in Kazakhstan

There are around 117,000 people who inject drugs in Kazakhstan^[2] with an HIV prevalence of 8.5% among this population.^[35] The HIV epidemic is concentrated among key populations, with injecting drug use accounting for a large proportion of people living with HIV.^[36]

Kazakhstan was allocated Global Fund money for harm reduction in 2003 (US\$8.0m), 2007 (US\$7.5m) and 2010 (US\$13.2m) with a large proportion of funding going towards needle, syringe and condom provision. As the country was one of the first in Eastern Europe and Central Asia (EECA) to gain upper-middle income status and had a low overall HIV prevalence, it became ineligible to apply for Global Fund grants in 2011, receiving no funding for new grants in the 2014-2016 allocation period. Global Fund Round 10 funds were still supporting harm reduction during this period. The national government also provided support to the operation of around 150 NSP sites within the country, reaching around 60% of people who inject drugs;^[37] however, civil society note that government support was significantly reduced in 2017.^[38] It is estimated that only 4.7% of the country's total HIV budget goes towards prevention and only 2.7% for prevention activities is targeted to people who inject drugs. Access to OST has been restricted to pilot programmes at 10 sites in three cities, with less than 1% of people who use opioids accessing programmes.^[37]

Since 2010, new HIV infections have increased by 39% and increasing HIV prevalence among people who inject drugs has meant that Kazakhstan became eligible to apply for Global Fund grants again for the 2017-2019 period. The Concept Note for the Global Fund funding request, however, focuses on linkage to services and there is little indication that funds, international or national, will be used to increase access to OST. A number of barriers to OST expansion exist, including legal and political barriers, a hostile public environment, lack of trained staff, supply issues and cost. With an estimated funding gap of US\$12.3 million,^[39] the government will need to invest heavily to increase access to OST. However, threats to OST programmes reported in early 2018^[40] have recently escalated, with the government considering ceasing their operation. This is a stark example of the political vulnerability of harm reduction programmes and has prompted civil society action in an attempt to hold the government to account.³⁶

36. See letter from Eurasian Harm Reduction Association delivered to the President of the Republic of Kazakhstan on June 26, 2018 here: <http://harmreductioneurasia.org/wp-content/uploads/2017/06/1.1.pdf>

The introduction of the Global Fund's Sustainability, Transition and Co-financing Policy in 2016 goes some way to try and mitigate the negative potential of donor withdrawal. When countries become ineligible for country grants, they can apply for one allocation term (three years) of transition funding, provided they can meet the 15% government co-funding requirement. All applications are required to have a focus on key populations, equating to over 50% of budgets for lower middle-income countries and 100% of budgets for upper middle-income countries. An amendment made to the policy at the most recent Global Fund Board meeting in Macedonia in May 2018, now allows the Global Fund Secretariat to make case-by-case requests for a second allocation term of transition funding, where deemed necessary. To determine this, the Global Fund will examine several factors, such as the latest available HIV incidence data as well

as domestic commitments, including 'concrete commitments to finance services for key and vulnerable populations'.^[41]

Another concern for harm reduction is the challenge of maintaining the 'quality' of programmes through the transition to government support. In some cases increased government support has led to implementation being transferred from non-governmental organisations (NGOs) to public health facilities, resulting in the closure of community organisations previously providing the services. Public health facilities are unlikely to provide the same quality of harm reduction intervention as NGOs, as they are less likely to engage communities in service provision, or tailor services to the community's needs. It is also reported that a common feature leading up to and during transition is an increase in programme coverage targets, which with stagnant or reducing funding levels can impact on service quality.^[38]

Harm reduction funding in Ukraine

Ukraine's HIV epidemic is concentrated among key populations, with people who inject drugs accounting for approximately 28% of those living with HIV in the country. Harm reduction programmes are well established, with the Global Fund investing significant amounts of money for harm reduction in Ukraine, amounting to US\$125.4 million over the period 2004-2014.³⁷ This support has allowed a large harm reduction programme to become available nationally with Global Fund-funded outreach prevention services reaching an estimated 62% of people who inject drugs in 2015.^[42] In total, US\$14.8 million of international donor funding for harm reduction was identified for 2016, the majority of which was from the Global Fund (76%).

This investment in harm reduction has contributed to a decrease in HIV prevalence among people who inject drugs since 2012, leading to Ukraine being seen as an example of harm reduction success. Despite improvements, injecting drug use still accounts for between 20% - 40% of new HIV cases and an estimated 30,000 to 35,000 HIV-positive people who inject drugs were reported to be unaware of their status in 2015.^[42] As of 2016, OST coverage is low and harm reduction services have been almost entirely funded by international donors.

However, as part of the Global Fund 2017-2019 grant agreement, the Government of Ukraine (GOU) committed to transition funding for key population prevention and OST away from the Global Fund to national funding. A Global Fund condition states that failure to do so will result in

37. Data on Global Fund harm reduction funding in Ukraine includes antiretroviral treatment identified as provided to people who inject drugs. This amounted to US\$23.3 million over the period.

15% of the total grant being withheld, amounting to around US\$27 million. The Global Fund's Office of the Inspector General, however, raised concerns about the GOU's readiness for transition, with no clear transition plan set out and uncertainty around the impact on reaching people who inject drugs when services are transitioned from NGOs to a government that criminalises drug use.^[43] First procurements of OST give some hope for the Ministry of Health's commitment to implementation of the transition plan.

However, questions have been raised around the quality of service provision in relation to OST and the role of the private sector and co-payment in delivering services. Initial delays in transitioning existing clients across to an OST programme financed by government raised doubts about the extent to which the government is able to scale-up OST provision as required. Community leaders are concerned about possible switching to the out-of-pocket payment to access OST treatment. Donor funding for advocacy will be crucial in ensuring a transition to government-financed OST programmes that are free, accessible and acceptable to people who use drugs.

It is clear that the Global Fund continues to be the most crucial donor for harm reduction. However, the allocation model, the strict eligibility criteria and transition away from middle-income country support are weakening the extent to which the Global Fund can fulfil this crucial role. Available data suggest that harm reduction allocations in 2016 are 18% less than that of 2011 and that emphasis on priority interventions may have reduced. While it is positive to see new countries include harm reduction components in their grants,^{38 [44]} the Global Fund is retreating from countries where the need is greatest and domestic investment is lacking.

Recommendations:

- The Global Fund should reinstate the successful MARPs Reserve approach from Round 10 (2010) to ensure harm reduction funding is made available at the required levels for countries to scale up their responses to UN-recommended harm reduction coverage.

- The Global Fund should not reduce or withdraw funds from countries until domestic support for harm reduction is in place.
- The Global Fund must do more to ensure that harm reduction is included in funding proposals where there is an epidemiological need for harm reduction interventions, in particular NSP and OST. To do this, the Global Fund must ensure that the Country Coordinating Mechanisms and Technical Review Panel include community representatives and harm reduction experts.
- The Technical Review Panel should rule technically unsound any proposals from countries with injecting-related HIV epidemics, which do not include budgeted funds for the provision of priority harm reduction interventions.³⁹
- The Global Fund must adopt a more flexible approach to funding eligibility to allow it to be more responsive to avert public health emergencies.⁴⁰ Noting the availability of quality

38. Including Benin, Burkina Faso, Burundi, Chad, Democratic Republic of Congo, Djibouti, Senegal, Sierra Leone and South Sudan <http://www.globalfundadvocatesnetwork.org/wp-content/uploads/2016/07/Cost-of-Inaction-2016.pdf>

39. Analysis of 119 proposals received by the Global Fund and reviewed by its Technical Review Panel showed that funding requests for key population programmes were often omitted from proposals even where the need had been identified. This information is taken from - Global Fund Advocates Network & International Civil Society Support. Investing in the Global Fund: The Cost of Inaction. Global Fund replenishment 2016. Amsterdam: International Civil Society Support; 2016

40. The eligibility policy currently requires countries to meet the eligibility criteria for two consecutive years before they can become newly eligible for an allocation. An eligibility criterion for high disease burden in concentrated epidemics is considered to be HIV prevalence of over 5%.

data on HIV among people who inject drugs (and other key populations) is often limited and/or outdated, when making decisions regarding eligibility and transitional funding, it is critical that the Global Fund relies not only on UNAIDS data, but also on data and evidence from wider sources including international and national civil society.

- The Global Fund must systematically monitor its allocations and spending on harm reduction. We welcome the plans to include key performance indicators to enable assessment of investment in key population programming and urge the Global Fund to share the results with national governments, donors and civil society to allow for transparent and coordinated planning.

- The Global Fund must maximise the potential for harm reduction to be supported with the US\$200 million catalytic investment allocation for HIV in 2017-2019, and the now-reduced funding for focused multi-country grants, recognising the multiple draws on these funds.
- When working with national governments on increasing domestic support for harm reduction, the Global Fund should call on governments to critically evaluate the public health impact and effectiveness of their drug control spending. This should include recommending that they redirect funds away from ineffective drug law enforcement towards harm reduction.

2.3 Bilateral funding for harm reduction

2.3.1 PEPFAR

Since its inception in 2003, PEPFAR has provided an estimated US\$70 billion for HIV/AIDS and tuberculosis programmes.^[45] PEPFAR was the first, and remains, the largest donor to the Global Fund, and its pledges have been instrumental in leveraging funds from other donor governments.^[46] PEPFAR's commitment to reaching key populations with programmes is articulated in its strategic vision 3.0 and listed as one of five programmatic priorities: *"Now more than ever, people who inject drugs, sex workers, and men who have sex with men face stigma and discrimination... If any one of our populations is left behind, we are all left behind and we will not control the epidemic."* – PEPFAR 3.0.^[47] In 2016, PEPFAR allocated US\$5.2 billion for bilateral programmes, with a further US\$1.4 billion allocated to the Global Fund. Our research shows that in that year, PEPFAR made the second largest donor contribution to harm reduction investment in LMICs.

While the term 'harm reduction' is not used in its strategic vision and PEPFAR does not fund the purchasing of needles and syringes, PEPFAR's prevention support does include three central elements of the UN-recommended comprehensive package to address HIV among people who use drugs:^[48] 'community-based outreach programmes; needle and syringe programmes (NSPs); and drug dependence treatment, including medication assisted therapy (MAT),⁴¹ with methadone or buprenorphine and/or other effective medications as appropriate, based on the country context'.^[49] Additional PEPFAR-funded activities, which may include harm reduction elements, include policy reform, training, capacity building, sexual transmission prevention programmes for people who inject drugs, community mobilisation and programmes that address non-injection drug use.

41. PEPFAR, and the US government more widely use the term MAT instead of opioid substitution treatment, which is predominantly used elsewhere in the world.

The most significant limitation to PEPFAR as a harm reduction donor stems from the US domestic legislation which continues to prohibit the use of federal funds to purchase sterile needles and syringes.^[50] The legislation does allow the use of federal funds for other needs of NSPs so, in practice, PEPFAR monies can be used to support the wider costs involved in providing NSP services, such as infrastructure and delivery costs. The implications of the 2017 expansion of the Mexico City Policy, or the 'Global Gag Rule', prohibiting US funds from going to NGOs that provide information, referrals or services related

to abortion, will have far-reaching impact for women in LMICs, including women who use drugs. Crucially, this is a barrier to integrated sexual and reproductive health and harm reduction services, which are already rare and underfunded.

PEPFAR support for harm reduction activities is limited to countries where there is existing PEPFAR activity and decisions on funding programmes for people who use drugs are taken on a country-by-country basis. PEPFAR has a focus on countries with large HIV epidemics and consequently Sub-Saharan Africa receives a considerable proportion of PEPFAR funds.

2.3.2 How much does PEPFAR invest in harm reduction?

PEPFAR demonstrates transparency in relation to its allocation and expenditure data, publishing several information sources online which can help to establish the extent of planned and actual investment in programmes for people who use drugs.⁴² Annual Country Operational Plans (COPs) underpin PEPFAR's work at a country-level and set out budget allocation and activity. Online 'dashboards' provide detail on budget allocations by areas of activity as well as actual expenditure, which has been tracked in all PEPFAR countries since 2014.^[51] However, the way in which budget allocations and expenditure are categorised means they cannot be compared to assess whether plans came to fruition. This may be particularly important for key population programming where political opposition can be a barrier to implementation.

A budget code, IDUP, captures funding allocations for HIV prevention programmes targeting people who use drugs (injecting and non-injecting),⁴³

whereas expenditure data is captured under two codes Medication Assisted Therapy (MAT)⁴⁴ and Sexual and Other Risk Prevention, Injection Drug User (SORP-PWID).⁴⁵ They also cover different time periods. Allocations in 2016 refer mostly to activities planned for 2017, whereas expenditure in a given year may be drawn from the previous year's allocation or earlier. For 2016, PEPFAR's expenditure relating to two expenditure codes (MAT and SORP-PWID) was recorded as being almost double the funding under the allocation code. Of note, PEPFAR also publish Sustainability Indices and Dashboards,^[52] which assess the sustainability of national HIV responses in PEPFAR countries. This is not currently a tool that allows assessment of the sustainability of the harm reduction response.

The budget allocation for 2016 programmes targeting people who use drugs was US\$14.0 million, accounting for 0.3% of PEPFAR's total bilateral budget.

42. As PEPFAR does not categorise allocations or spending using the term harm reduction, it should be noted that there may be activities not strictly considered harm reduction being coded to these budget and expenditure lines.

43. The IDUP budget code includes HIV prevention activity for people who use drugs covering both NSP and OST. For a full description of the budget code see Appendix E.2.6: https://et.usembassy.gov/wp-content/uploads/sites/188/2017/04/COP17-Guidance_18JAN2017.pdf

44. This programme area includes provision of opiates such as methadone for people who inject drugs. Expenditures related to outreach mobilization, and other ancillary services provided to opioid substitution therapy (OST) clients should be estimated and reported under the SORP-PWID program area.

45. This programme area includes services and support for individuals or small groups among injection drug users for the provision of HIV prevention interventions that are based on evidence and/or meet the minimum standards required.

PEPFAR allocated 20% of its budget to HIV prevention broadly,⁴⁶ ranging from 10% in Ukraine to 39% in Myanmar. But prevention for people who use drugs amounted to an average of 1.2% of the overall country and regional budgets, ranging from 0% in South Africa to 19.7% in the Central Asia Regional programme.⁴⁷

However, upon examination of actual expenditure data for 2016, **a total of US\$25.8 million was spent on interventions for people who inject drugs, of which 34% was used to fund MAT programmes.** This equates to 0.5% of PEPFAR's total bilateral budget. PEPFAR reported to HRI that these funds covered NSP programme delivery costs, as well as capacity building and advocacy work related to service provision for people who inject drugs and related policy. This also includes some funding for prison programmes and there are plans for this funding to increase. The 2017 Ukraine COP states that PEPFAR will support the Ministry of Justice to introduce MAT and a package of HIV prevention services for people who inject drugs within pre-trial detention centres and prisons.

In 2016, PEPFAR's largest harm reduction expenditure was in Vietnam (US\$5.3 million) although this was a reduction from 2015 expenditure (US\$8.2 million) and is anticipated to reduce further as the national government moves towards fully funding the provision of methadone and services to people who inject drugs. Most of the countries with significant harm reduction funding from PEPFAR also receive harm reduction funding from the Global Fund. India is the exception to this, where a total of US\$2.1 million was spent by PEPFAR in 2016, 16% of which went to MAT. PEPFAR is the largest international donor

for harm reduction in some countries, including Kenya and Tanzania.

Of 22 PEPFAR country programmes with reported expenditure on programmes for people who use drugs in 2016, 12 are in countries with no NSP or OST services.⁴⁸ The funds for harm reduction are relatively small when compared with the overall country grants, amounting to US\$5.4 million in 2016, and representing 21% of PEPFAR's harm reduction investment that year. With its emphasis on sub-Saharan African countries, PEPFAR has the opportunity to support the introduction of priority harm reduction interventions and prevent growing HIV epidemics among people who use drugs.^[53] To do this, it must ensure appropriate funding goes towards priority interventions and the work necessary to ensure their effective implementation, including advocacy and policy reform.

However, a recent review found that NSPs and policy reform were among the least frequently funded activities within PEPFAR supported programmes for people who inject drugs, mentioned in only 13% of reports, raising a concern that the most effective interventions for this key population are not receiving high enough priority.^[54] In Nigeria, for example, PEPFAR expenditure was over US\$4 million, but country operational plans for 2016 and 2017 do not mention NSP or OST. However, PEPFAR's online dashboard indicates that the HIV prevention among key population targets was surpassed in 2016, with the indicator being 'number of key populations reached with individual and/or small group HIV preventative interventions that are based on evidence and/or meet the minimum standards required'.

46. The Planned Funding Prevention program area encompasses the following Budget Codes: Blood Safety (HMBL), HIV Testing and Counseling (HVCT), Injection Safety (HMIN), Injecting and Non-Injecting Drug Use (IDUP), Prevention of Mother to Child Transmission (MTCT), Sexual Prevention: Abstinence/Be Faithful (HVAB), Sexual Prevention: Other Sexual Prevention (HVOP), and Voluntary Medical Male Circumcision (CIRC).

47. PEPFAR dashboard data: <https://data.pepfar.net/global>

48. Angola, Burundi, Haiti, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Sudan, Uganda, Zambia and Zimbabwe.

As the second-largest donor to harm reduction in LMICs, PEPFAR's significant omission of funding for NSPs and policy reform leaves a considerable gap in essential financial support for the full range of harm reduction interventions recommended by both its own^[55] and international guidance.^[56] Furthermore, interventions such as the peer-distribution of naloxone and the provision of hepatitis C treatment do not feature in the majority of PEPFAR funded programmes. Naloxone is mentioned only three times within 2010-2015 country and regional operational plans,⁴⁹ while hepatitis C treatment receives similarly few mentions within planning documents. In order to maximise the impact of PEPFAR funds in curbing epidemics among people who use drugs, PEPFAR must ensure priority harm reduction intervention are supported.

To provide a full picture of PEPFAR investment in harm reduction, it is also important to note several separate funding channels not captured within the online dashboards. Of note, PEPFAR headquarters has funded multi-year key populations-related initiatives, including the Key Populations Challenge Fund, the Key Populations Implementation Science Initiative, and the Local Capacity Initiative, which all potentially have some elements targeting people who use drugs, in addition to other key populations. Moreover, PEPFAR also committed US\$10 million of funding to the 2016-2018 round of the RCNF and announced the creation of the US\$100 million Key Populations Investment Fund in 2016, which has yet to be implemented.^[57] However, taken together with its direct funding for harm reduction programmes, this still represents a tiny fraction of PEPFAR's overall budget.

PEPFAR spent 0.5% of its total bilateral budget on harm reduction in 2016.

PEPFAR remains a crucial donor for harm reduction, both bilaterally and via its support for the Global Fund. However, more must be done to ensure that PEPFAR funds are used optimally and invested in the most effective, evidence-based harm reduction interventions for people who use drugs.

Recommendations:

- PEPFAR should demonstrate its prioritisation of key populations by increasing the overall funding going towards these programmes – including for harm reduction – in line with epidemiological need. Despite PEPFAR being the second-largest harm reduction donor in 2016, this represents only 0.5% of PEPFAR's overall bilateral funding.
- PEPFAR must fund all of the UN-recommended interventions to address HIV among people who use drugs, prioritising NSP (including the procurement of needles/syringes) and OST. PEPFAR should further fund treatment and prevention for hepatitis C and overdose prevention interventions, including naloxone.
- PEPFAR must make their allocation and expenditure data comparable so that this data can be meaningfully used to track whether money is being spent as planned.
- PEPFAR should ensure the Sustainability Indices and Dashboards can be used to assess the sustainability of the HIV response for key populations, including people who use drugs.

49. An online search using <http://copsdata.amfar.org/about> found one in Nigeria (2012) in relation to advocating for it to be listed as an essential medicine, one in Tanzania (2010) referring to work with the Ministry of Health and Social Welfare (MOHSW) in Zanzibar to introduce overdose prevention tools and Naloxone overdose treatment and one for the Central Asia Regional project (2012) to develop skills on overdose prevention and naloxone use. It should be noted that PEPFAR COPS/ROPs denote planned not reported activities.

2.3.3 Other bilateral funding for harm reduction

When we conducted research in 2007, donor governments contributed a large share of global harm reduction funding through bilateral support to individual countries and regional programmes. For example, DFID was the second largest donor after the Global Fund, contributing an estimated US\$41 million to harm reduction programmes, one-quarter of identified funding at that time. Since then, governments have been moving away from investing in harm reduction through bilateral programmes, with money increasingly channelled through multilaterals, such as the Global Fund and the UN. These investments are not harm reduction-specific but often part of wider HIV funding pots. Donor governments contacted as part of this research have, therefore, found it difficult to identify the extent to which the money they invest goes towards harm reduction.

Despite the difficulty in isolating harm reduction spend, it is evident that overall funding levels for harm reduction have not been maintained

through multilaterals. Although contributions to the Global Fund from the UK more than doubled between 2008-2010 and 2014-2016 from US\$571 million to US\$1.26 billion,⁵⁰ the increase in harm reduction funding through the Global Fund between 2007 and 2016 of US\$35 million is less than the amount of DFID funding identified in 2007 (US\$41 million), representing an even bigger reduction in real terms.

In addition, no bilateral harm reduction funding for AusAID has been identified in this study compared to 2007, when its US\$16.2 million contribution made AusAID the third-largest donor. This has not only affected the overall amount of funding for harm reduction in LMICs, but has had a large impact on individual countries that previously benefited from bilateral support. For example, when AusAID finished funding harm reduction in Indonesia in 2015, NGOs providing harm reduction services to people who use drugs were unable to operate.^[58]

Harm reduction funding in Indonesia

Indonesia has a concentrated HIV epidemic, with HIV prevalence high among the 74,000 people who inject drugs in the country. Harm reduction was introduced in 2001, funded by international donors, several of which have continued to finance harm reduction efforts within the country. It is estimated that around US\$18million of funding for harm reduction was provided by international donors in 2006 through DFID, AusAID and USAID.^[8] At the time, HIV prevalence among people who inject drugs was estimated to be 52%. Following the expansion of harm reduction services, the HIV prevalence among people who inject drugs dropped to 41%, but the harm reduction response remained vulnerable and heavily reliant on uncertain donor support.

When USAID completed its funding cycle in 2010, services that had been running for five years were forced to close. While PEPFAR continues to have a presence in Indonesia, harm reduction expenditure in 2016 amounted to only US\$0.5 million.

The Australia Indonesia Partnership for HIV provided funding for harm reduction through AusAID from 2008 until 2015, when HIV prevalence was reported to have fallen to around 29%. Yet similar

problems to 2010 were reported at its conclusion, with the closure of services previously funded by the donor programme. HRI country-level research found an estimated \$2.7 million of harm reduction expenditure in 2016, comprised mostly of Global Fund monies (\$2.4 million).^[58] This is well below levels 10 years ago and despite signs that the numbers of people injecting drugs may have decreased, the investment is still too low to sustain an effective harm reduction response. There is a paucity of policy and programming that respond to the harm reduction needs of increasing numbers of people who use stimulants in Indonesia,^[59] (a project funded by Mainline and operating in Jakarta in 2016 being the exception), and very little developed for women who use drugs.^[60] With the recent change in the Global Fund Eligibility Policy,⁵¹ Indonesia will continue to be eligible for country allocations upon becoming an upper middle-income country, while there continues to be a high HIV burden among key populations. There is a need for the Global Fund to address these neglected areas when apportioning funding for programmes reaching people who use drugs in Indonesia.

Establishing the full extent of harm reduction investment by the Indonesian Government was not possible as data, particularly funds coming from local government, were not available. It is clear, however that the extent to which the government has taken financial responsibility for harm reduction compares poorly with that of the overall HIV response, where 57% of total expenditure comes from the government.^[61] The only estimate of financial support available for 2016 was a modest investment for the purchasing of methadone, enough for just 2,000 people. In a domestic environment that prioritises drug control and practices mandatory rehabilitation – US\$192 million was provided through the National Anti-Narcotics Agency for narcotics prevention and eradication efforts in 2016^[62] – harm reduction looks set to continue to be overly reliant on shrinking donor funds.

Outside of PEPFAR, the Ministry of Foreign Affairs of the Netherlands (MoFA) stands out for its significant bilateral support for harm reduction. In 2016, it was estimated that US\$4.1 million was spent on harm reduction, the majority of which (US\$3.4m) was through the Bridging the Gaps programme, a consortium of Dutch NGOs and international networks working with key populations including people who use drugs.

The MoFA contributed US\$13.8 million for the Community Action on Harm Reduction (CAHR)⁵² programme between 2011 and 2015. Following the cessation of CAHR funding at the beginning of 2016, the MoFA continued supporting harm reduction through Strategic Funding

of CAHR's main implementation organisation, the International HIV/AIDS Alliance (IHAA). This amounted to US\$294,000 in 2017, a small proportion of the annual funding available under CAHR.

The Netherlands MoFA has also committed funding for harm reduction under the Partnership to Inspire, Transform and Connect the HIV response (PITCH) programme, which runs from 2016 to 2020. It was expected that US\$1.5 million would be spent annually on advocacy for people who use drugs and harm reduction, though the expenditure identified for this programme by IHAA in 2016 was considerably lower. Through the PITCH and Bridging the Gaps projects, the MoFA

50. See Global Fund pledges and contributions on the Global Fund website.

51. The removal of the G20 rule.

52. Countries involved in CAHR were China, India, Indonesia, Kenya, Malaysia and later Myanmar

continues to provide support to harm reduction and human rights for people who use drugs in middle-income countries.

While it was possible to identify all harm reduction funding from donor governments, our research sought to document all substantial contributions. There may be some expenditure from wider programmes and those coming to an end in 2016; for example, Norway Funds provided US\$1.5 million of funding between May 2014 and April 2016 under the project, 'Strengthening

the prevention and control of HIV/AIDS, HBV and HCV in Romania'. A proportion of this money would have been spent in 2016 on prevention among people who inject drugs. In addition, the French Government report that there may be some international funding for harm reduction through city cooperation, for example between Paris and Dhaka. Some funding from the German Government and the Swiss Government may also have supported harm reduction research and policy activities in 2016.

Harm reduction funding in Vietnam

Injecting drug use is a key contributor to the HIV epidemic in Vietnam, with a large population of people who inject drugs estimated to be 226,860 in 2016. Efforts to address the epidemic increased in 2004 with the development of the first national HIV Strategy. Investment in HIV programmes and harm reduction was driven by a sizeable international donor presence, a large proportion of funding coming from bilateral contributions, particularly from the US Government. The World Bank and DFID funded a comprehensive harm reduction programme between 2003 and 2013 consisting of NSP, condom distribution, peer outreach, drop-in centres, behavioural change, OST and advocacy. The Global Fund provided minimal harm reduction funding until 2009 when US\$29.4m was allocated to the country.

The scale-up of harm reduction services such as NSP has been credited with helping to control the HIV epidemic among people who inject drugs.^[63] Estimated NSP coverage increased substantially between 2006 and 2011.^[64] Despite the achievements, coverage of OST remained sub-optimal, with a repressive political environment threatening improvements and an over-reliance on donor support jeopardising sustainability. In the evaluation of the World Bank/DFID programme in 2013, concerns were raised about the *"lack of a transitional strategy to secure domestic funding for harm reduction interventions"*.^[64]

The Government of Vietnam aimed to reduce dependency on international donor support for HIV programmes to less than 50% by 2015 and less than 25% by 2020. However, government funding of the HIV programme, the National Targeted Program, under which methadone maintenance is provided to people who inject drugs, reportedly reduced from US\$12 million in 2012 to US\$4 million in 2014.^[65] PEPFAR reduced funding over this period through a planned transition with a decrease in allocations from US\$10.1 million in 2013 to US\$1.5 million in 2016. The Global Fund took on some of the funding of OST after the end of the World Bank/DFID programme, with the Vietnamese government gradually taking on the financing of OST and due to fully-fund this programme in 2018.

Vietnam is still heavily dependent on donor support for NSPs, with 90% of funding coming from donors in 2016, primarily the Global Fund. From 2016, after the ending of the National Targeted Program in 2016, the HIV programme was subsumed within a wider National Health Priority Programme and competes with other health priorities for funding on an annual basis. Questions therefore remain around whether the Vietnamese Government will provide the necessary financing to fund harm reduction services long-term at the level necessary to control the epidemic. Furthermore, despite the Vietnamese Government passing legislation that allowed the expansion of OST, the political environment is still restrictive. Further complicating this picture is the presence of, and government investment in, compulsory detention centres, where people who use drugs are detained and have no access to harm reduction services, despite evidence of improved outcomes for community-based harm reduction services compared to compulsory detention.^[66]

2.4 Philanthropic funding for harm reduction

At US\$465 million, private philanthropy accounted for only a small proportion (2%) of the estimated overall HIV spend in LMICs in 2016.^[67] Notably, unlike donor government funding, which has been decreasing, philanthropic funding for HIV has increased for two years running.^[67] However, very little funding for harm reduction comes from philanthropic donors. This study identified only US\$6.3 million in 2016, which amounts to 1% of philanthropic donor funds for the HIV response in LMICs.^[67] The majority of this was from OSF, primarily for advocacy work. EJAF UK and EJAF US also report harm reduction funding, with US\$1.1 million going to LMICs in 2016.⁵³

Philanthropic donors contributed US\$6.3 million for harm reduction in 2016, just 1% of total philanthropic donor funding for the HIV response.

As is the case for other donors, disaggregating harm reduction spend is difficult for philanthropic organisations. A study by Funders Concerned about AIDS (FCAA) identified philanthropic donor funds for programmes for people who inject drugs in 2016.^[67] However, much of the funding was not directed to LMICs⁵⁴ and a significant amount is likely to have been 'peripheral funding' with support for programmes for key populations, rather than directly funding harm reduction services.^[68] A large proportion of the harm reduction funding identified in the study was from the Bill & Melinda Gates Foundation (Gates Foundation). However, our communication with the Gates Foundation suggests that there was very little funding of harm reduction in 2016, with most HIV funding going to countries in Sub-Saharan Africa.^[68] In 2007, US\$4.8 million was identified from the Gates Foundation for programmes running in India and China, with other funding also identified in Russia, but this still amounted to a small proportion of their HIV funds overall.

53. EJAF US funds for LMICs are focused on Mexico and the Dominican Republic, with the rest of its harm reduction funding going to the US.

54. Half was directed towards the United States.

The Gates Foundation is the largest philanthropic HIV donor, contributing US\$238 million in 2016 globally, amounting to 35% of all HIV funding from philanthropic donors.^[67] The Gates Foundation also makes a significant contribution to the Global Fund – totalling US\$1.6 billion to date.^[69] The Gates Foundation's strategy, includes a focus on 'high-risk populations', stating: '[we] concentrate on areas where existing funds are insufficient, our support can have potentially catalytic impact, and we can assume risks that others may not be able to'. The Gates Foundation is ideally placed to fund harm reduction. Their absence, and that

of other large philanthropic HIV donors, is hugely problematic and a significant contributing factor to the funding crisis which must be questioned.

Recommendations:

- Philanthropic donors, particularly those who contribute large amounts for HIV funding more broadly, must commit more funding to harm reduction.
- Philanthropic donors must leverage their access, position, and power as funders to call for other philanthropic, national and multilateral donors to increase their commitments to harm reduction.

3. Domestic funding of harm reduction

3. Domestic funding of harm reduction

Determining the extent of domestic funding for harm reduction remains a difficult task. Statements of planned funding, for example, through policy documents such as National Plans, are often not followed through with actual investments and health spending is not disaggregated to the level required to identify investments in programmes for people who inject drugs. A key data source for tracking HIV expenditure has been the UNAIDS National Aids Spending Assessment (NASA) exercises, despite some reservations about the accuracy of the information provided by national governments.^[8]

The NASA reports represent the only unified approach to identifying what is spent on key components of a country's HIV response. The detail provided within the reports can vary, however, with some only disaggregating spend down to prevention rather than further identifying the amount that goes towards prevention for key populations such as people who inject drugs. Furthermore, these documents are no longer routinely made available to the public, with most reports on the UNAIDS website being 5 to 10 years old. Some further data were obtained for this study from UNAIDS, but there are very few recent data,^[70] with only Ukraine having data recent enough to be useful for this study.

Without this key source of information, it is necessary to draw upon a wide range of different sources and material, which are often contradictory and do not allow direct comparison across countries. These include budget plans, Annual Reports, individual studies, donor

reports, funding applications, NGO reports, programme evaluations and key informant reporting. The variation in both the quality and quantity of the data makes it difficult to draw firm conclusions about the extent to which national governments in LMICs are funding their harm reduction responses.

Domestic investment in harm reduction was estimated to be US\$48 million in 2016.

HRI arrived at a best possible estimate of US\$48.1 million domestic investment in harm reduction in 2016, or nearest year.⁵⁵ This equates to 26% of all identified harm reduction spending and comprised identified national investment data for 19 countries. Domestic investment of over US\$1 million was identified in India, China, Vietnam, Malaysia, Kazakhstan, Iran, Georgia, Ukraine, Thailand and Myanmar. Table 5 contains the best available information on countries where there are estimated to be over 100,000 people who inject drugs. As the table shows, data sources, year of data and parameters differ between countries. Therefore, no cross-comparisons can be made and all data must be interpreted with caution. It is also of note that where harm reduction funding data is available, this is often not accompanied by a breakdown of spend by intervention, which clouds the extent to which government investment can be critically evaluated.

55. Efforts were made to find data from the year 2016, but when this was unavailable, data from 2015, or 2014 were used. For Iran, it was necessary to use data for 2012 as no more recent data were available and Iran recorded a large amount of harm reduction spend in this year. The amount of funding identified for China (data was available for Yunnan province only) was for 2013.

Table 5: Available data, sources and uncertainties identified on domestic harm reduction investment in countries with over 100,000 people who inject drugs

Country	Domestic investment (in US\$ millions)	Domestic investment as a % of harm reduction funding	Information provided within source document on services funded	Latest UNAIDS national data ⁵⁶	Source and comments
China	1.1	100%	OST primarily, NSP not supported to same extent	None available	No data available on national expenditure. Data for 2013 for Yunnan
Russia	N/A			None available	Municipality of St Petersburg reported to provide some support to NSP.
India	11.0	81%	More expenditure on NSP than OST	2013	HRI funding assessment research 2016 data
Brazil⁵⁷	N/A			None available	Indications of some local level domestic spend on harm reduction for crack use.
Ukraine	1.1	14%	No information on what this expenditure covers within source document	2015	UNAIDS data 2015
Vietnam	10.2	41%	No national government funding of NSP, only OST	2012	HRI funding assessment research 2016 data

56. Some data were provided directly by UNAIDS to HRI, so not all is in the public domain.

57. It should be noted that the population size estimate for people who inject drugs in Brazil is considered an overestimate, with recent unpublished research suggesting very few people inject drugs in the country.

Country	Domestic investment (in US\$ millions)	Domestic investment as a % of harm reduction funding	Information provided within source document on services funded	Latest UNAIDS national data	Source and comments
Iran	9.9	84%	No breakdown of funding by service type in source document	2012	UNAIDS data 2012
Malaysia	5.4	95%	No breakdown of expenditure but harm reduction programme includes both OST and NSP	None available	Global AIDS Response Progress Report 2016. Data from 2015.
Mexico	N/A			2011	Civil society report a small amount of harm reduction funds from government through the national HIV programme.
Kazakhstan	3.6	93%	Most funding for NSP, small amount for OST	2014	Figure represents planned funding for NSP and OST in 2016 from Harm Reduction Works project.
Pakistan	N/A			2013	

A major gap in data on domestic investment is China, where an estimated 2.6 million people who inject drugs live and where the government is supporting OST and NSP provision nationwide. A NASA report for China was published in 2010 but this included data from a pilot assessment in one province and did not cover the whole country. The most detailed and up-to-date estimates of national government expenditure on harm reduction have been obtained from civil society; for example, an HRI study tracking harm reduction investment in seven countries in Asia (Cambodia, India, Indonesia, Nepal, Philippines, Thailand and Vietnam).⁵⁸ Using a standardised tool and a network of consultants within countries,

estimating investment in key harm reduction interventions and identifying funding sources has been possible. Understanding the extent and size of national government investment in harm reduction is essential to assess the sustainability of the response and to ensure that harm reduction does not become even less of a priority during transition to national funding. By providing detailed expenditure data, it is also possible to assess how comprehensive the harm reduction response is. Table 5 shows that some governments mainly fund OST while others fund mainly NSP.

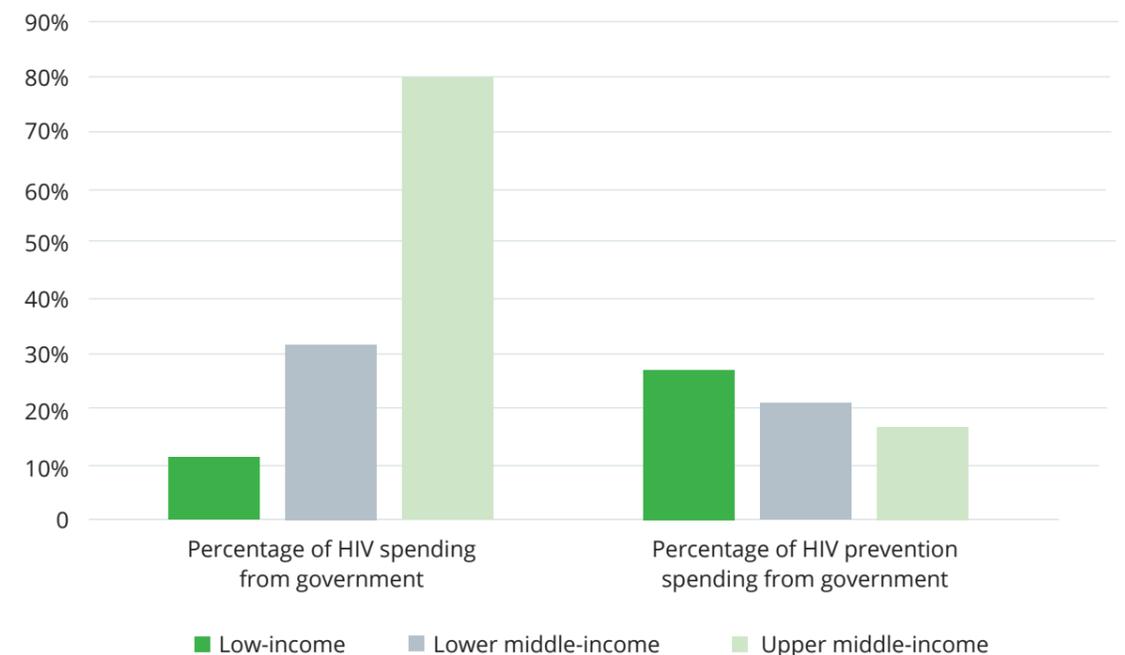


Figure g: Percentage of HIV spending from government alongside percentage of prevention spending from government

58. An HRI report and the research tools will be published 2018-19. Please contact HRI for more details.

Putting the findings in table 5 into perspective, while 10 countries spend over US\$1 million on their national harm reduction programmes, and six provide the majority of harm reduction funding in their countries, often this is a small percentage of their national HIV investment. For those countries with identified domestic investments in harm reduction, on average this equated to less than 5% of the total (donor and government) HIV investment and 13% of total (donor and government) HIV prevention investment.⁵⁹

The only countries with national harm reduction investments representing over one-third of their HIV prevention investments were Malaysia and Kazakhstan. (See above case study on Kazakhstan, including recent threats to the OST programme.)

While it has not been possible to come up with comparable estimates of national spend on harm reduction in this study, data from the Institute for Health Metrics and Evaluation⁶¹ show that upper middle-income countries fund more of their overall HIV response than lower middle-income and low-income countries. However, prevention⁶⁰ accounts for a lower percentage of the overall response in these countries.⁶¹

Recommendations:

- Governments must fund harm reduction programmes for people who use drugs, ensuring that funds effectively respond to the national context. Funding should include, but not be limited to, the UN-recommended package of interventions for people who use drugs. Governments should also support the development of harm reduction interventions for people who use stimulants.
- Governments must accurately track harm reduction allocation and expenditure in their countries, including via the UNAIDS NASA, to allow them to measure the impact of their investments and to inform future budget allocations.
- Governments must ensure civil society and people who use drugs remain central to the design and delivery of domestically-supported harm reduction programmes. This will require mechanisms for contracting NGOs and the meaningful involvement of people who use drugs in all aspects of policy and programmes.
- Governments should critically evaluate their drug control spending, its efficacy and cost-effectiveness, with a view to shifting funds away from ineffective and often harmful drug law enforcement towards harm reduction.

59. Calculations informed by data from TABLE B7: Health spending on HIV/AIDS, 2015 in IHME Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda. <http://www.healthdata.org/policy-report/financing-global-health-2017>. Data was provided to HRI on a non-adjusted basis by the study author at IHME.

60. Currently, IHME prevention estimates include prevention of mother-to-child transmission (PMTCT). IHME hope to separate these out in future.

Methodology

This study aimed to build upon previous work undertaken by HRI to estimate expenditure on harm reduction in LMICs.^{[8] [10]} As in the previous studies, there is no single source of information available on this topic, so the task was divided into two main elements; a survey of international donors; and estimates of national government expenditure.

To estimate international donor spend, a survey instrument was designed to collect data on overall harm reduction expenditure using 2016 as the reference year and broken down by category of spend (health services, capacity building, advocacy and research). In addition, expenditure by recipient country was requested alongside contextual information on the types of activities funded. A list of donors was drawn up based on HRI's knowledge of the funding landscape and suggestions from key informants in the harm reduction field. Surveys were sent via email in January 2018 to 22 donors. Further possible donors were identified and sent a survey if relevant. Information from 14 donors was received including nine completed survey responses. Other donors provided information via email or telephone call. All non-respondents were followed-up on two or more occasions. Information provided by donors was checked with implementing organisations and key contacts where relevant. Where identifiable, harm reduction funding for high-income countries was excluded from the analysis. Double counting was considered both in the formulation of the survey questions and was checked for in follow-up conversations with donors and implementing agencies. Particular efforts were made to ensure that multilateral and UN contributions from donor governments were only counted once. Checks

made leave us confident that any remaining double-counting would be insubstantial.

Where no response was received, efforts were made to check other data sources, including donor websites, the OECD's International Development Statistics (IDS) online database and individual country reports. Implementing organisations and contacts within countries were also contacted to see if funding could be identified that way. This allowed us to be confident that any international donor funding not captured through our survey or other data gathering activities, would not significantly impact upon the total harm reduction investment figures.

Information on further harm reduction expenditure including national government expenditure was collected from a number of sources including UNAIDS NASA reports, budget plans, Annual Reports, individual studies, donor reports, funding applications, NGO reports, programme evaluations and key informant reporting. This was cross-referenced with country spend information provided by international donors and an overall harm reduction funding figure for 2016 was estimated.

One of the primary issues with the data received is that for many donors and governments, expenditure data are not available, so the data reported refer to allocations and budgets rather than actual expenditure. Given that there are reports of countries not being able to spend funding allocations (the Global Fund estimates a 70% absorption rate across its portfolio), we can assume that the international donor spend represents a maximum amount.

There were some large countries, particularly in South America (Brazil and Argentina) where we

were unable to find much national spend data on harm reduction funding. We cross-checked with the responses from the Global State of Harm Reduction 2018 data-gathering exercise and key country informants to assess the impact of this. In most cases, there appeared to be little funding going towards harm reduction services in these countries. An important exception to this is China, where funding data was outdated and limited to Yunnan province, but where we know there are extensive harm reduction programmes supported by the Chinese government.

Analysis of the data was carried out in Excel. Countries were grouped by income status using the FY2016 World Bank classification. Russia was included in the analysis despite being classified as a high income country in 2016 as this classification occurred for only a short period of time and the funding of harm reduction services is a key concern in Russia given the size of the population who inject drugs.

Where trends in expenditure/funding are presented, these have been adjusted to 2016 prices using the US Bureau of Labor Statistics CPI data for January of each year.⁶¹

Data on harm reduction investments from the Global Fund are for allocations rather than expenditure. In the previous rounds-based funding cycles, allocations were spread over a number of years, which makes analysis of trends difficult. In order to adjust for this and

attempt to come to figures more likely to represent actual year-on-year changes in harm reduction funding, we undertook a re-analysis of the figures in Bridge et al. (2016). This involved going back to the original spreadsheets for each individual round and extracting the data on funding for each component (e.g. NSP, OST) by year (i.e. year 1, year 2 etc.). It was assumed that year 1 for each grant was the year after the allocation, so for 2008, year 1 was labelled as 2009, year 2 as 2010 and so on. A random grant was chosen from each funding round to check this assumption by looking at the start date and apart from the initial rounds in 2002 and 2003, this appeared to be a valid assumption. Data for each funding round were therefore labelled this way and consolidated into a worksheet containing funding data by individual year.

Unfortunately 2014-2016 data from the new grants following the change to the allocation funding model were not provided in sufficient detail to enable this adjustment to be made for those years. It is recommended that the Global Fund provides data on disbursements or expenditure so that trends in funding levels can be assessed accurately.

References

1. Harm Reduction International. What is Harm Reduction? A position statement. London: 2010.
2. Stone, K. Global State of Harm Reduction 2016. London: Harm Reduction International; 2016.
3. Larney S, Peacock A, Leung J, Colledge S, Hickman M, Vickerman P, et al. Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review. *Lancet Glob Health* 2017;5(12):e1208–20.
4. UNAIDS. A new investment framework for the global HIV response. Geneva: UNAIDS; 2011.
5. UNAIDS. 2016-2021 Strategy - On the Fast-Track to end AIDS. Geneva: UNAIDS; 2015.
6. UNAIDS. Do No Harm: Health, human rights and People who use drugs. Geneva: UNAIDS; 2016.
7. Cook C, Phelan M, Sander G et al. The Case for a Harm Reduction Decade: Progress, Potential and Paradigm Shifts. London: Harm Reduction International; 2016.
8. Stimson G, Cook C, Bridge J et al. Three cents a day is not enough Resourcing HIV-related Harm Reduction on a Global Basis. London: Harm Reduction International; 2010.
9. UNAIDS. Get on the Fast Track - the life cycle approach to HIV. Geneva: UNAIDS; 2016.
10. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance. The Funding Crisis for Harm Reduction: Donor Retreat, Government Neglect and the Way Forward. London: Harm Reduction International; 2014.
11. Sustainable development goals - United Nations [Internet]. [cited 2018 Jun 27]; Available from: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>
12. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030: Resolution adopted by the General Assembly on 8 June 2016. 2016.
13. UNAIDS. Towards a global HIV prevention coalition and road map. Preventing and reducing new HIV infections by 75% by 2020. Geneva: UNAIDS; 2017.
14. Resources and financing for the AIDS response [Internet]. [cited 2018 Jun 27]; Available from: <http://www.unaids.org/en/topic/resources>
15. UNODC response to HRI survey on funding for harm reduction. 2018.
16. UNAIDS & Kaiser Family Foundation. Donor government funding for HIV in low- and middle-income countries in 2016. Geneva: UNAIDS; 2017.
17. Ministry of Health, Kenya & National AIDS Control Council, Kenya. Kenya AIDS response progress report 2016. Government of Kenya; 2016.
18. Ministry of Health, Kenya & National AIDS Control Council, Kenya. Kenya national AIDS spending assessment report for the financial years 2009/10-2011/12. Government of Kenya; 2014.
19. PEPFAR. Kenya Country Operational Plan (COP) 2017 Strategic Direction Summary. Washington: PEPFAR; 2017.
20. Ministry of Health, Kenya & National AIDS Control Council, Kenya. Kenya AIDS strategic framework 2014/2015 – 2018/2019. Nairobi: Government of Kenya; 2014.
21. UNAIDS. Implementation of the HIV Prevention 2020 Road Map: First progress report. Geneva: UNAIDS; 2018.
22. Treat Asia. Hepatitis C: Policy Recommendations for Addressing a Growing Epidemic. Washington: AmfAR; 2018.
23. Global Fund. Harm reduction for people who use drugs: Information note (Round 10). Geneva: Global Fund; 2010.

61. Available online here: <https://www.bls.gov/cpi/tables/supplemental-files/historical-cpi-u-201805.pdf>

24. The Global Fund. The Global Fund to Fight AIDS, Tuberculosis and Malaria Fourth Replenishment (2014-2016) The Global Fund's New Funding Model. Geneva: The Global Fund; 2013.
25. Eligibility & Transitions [Internet]. [cited 2018 Jun 27]; Available from: <https://www.theglobalfund.org/en/funding-model/funding-process-steps/eligibility-transitions/>
26. Bridge J, Hunter BM, Atun R, Lazarus JV. Global Fund investments in harm reduction from 2002 to 2009. *Int J Drug Policy* 2012;23(4):279–85.
27. Department for International Development (DFID). Towards zero infections The UK's position paper on HIV in the developing world May 2011. DFID; 2011.
28. Oberth G, Torres MA, Mumba O, O'Connor M. A Quarter for Prevention? Global Fund Investments in HIV Prevention Interventions in Generalized African Epidemics. *Univ J Public Health* 2017;5(5):231–41.
29. Traynor D for The Global Fund. Summary overview of investments in programs for people who use drugs: Allocation period 2014 to 2016. Presented to the Strategic Advisory Group to the UN on HIV and drug use, 2018.
30. The Global Fund. Projected Transitions from Global Fund support by 2025 – projections by component: March 2018 update. Geneva: The Global Fund; 2018.
31. Dispute erupts on Moldova CCM; Global Fund Secretariat declines to intervene | Aidspace [Internet]. [cited 2018 Jun 27]; Available from: http://www.aidspace.org/gfo_article/dispute-erupts-moldova-ccm-global-fund-secretariat-declines-intervene
32. Concluding observations on the third periodic report of the Republic of Moldova. Geneva: Committee on Economic, Social and Cultural Rights; 2017.
33. Cook C. Harm reduction investments in the European Union: Current spending, challenges and successes. London: Harm Reduction International; 2017.
34. Open Society Foundations Public Health Program. Lost in Transition: Three Case Studies of Global Fund Withdrawal in South Eastern Europe. New York: OSF; 2017.
35. UNAIDS - KEY POPULATIONS ATLAS [Internet]. [cited 2018 Jun 27]; Available from: <http://www.aidsinfoonline.org/kpatlas/#/home>
36. Government of Kazakhstan. HIV yesterday, today and tomorrow: Implementation of national HIV response measures in the republic of Kazakhstan. Almaty: Government of Kazakhstan; 2017.
37. Eurasian Harm Reduction Association. Road to Success: Towards Sustainable Harm Reduction Financing Regional report. Harm Reduction Works – Fund It! Vilnius: Eurasian Harm Reduction Association; 2015.
38. Eurasian Harm Reduction Association. EHRA Global State of Harm Reduction survey response to HRI. Vilnius: Eurasian Harm Reduction Association; 2018.
39. Eastern Europe and Central Asia Union of PLWH & Eurasian Harm Reduction Association. Regional Report: Programmatic and Finance Gaps for Key Populations in a Selection of Eastern Europe and Central Asia Countries. Vilnius: Eurasian Harm Reduction Association; 2017.
40. Canadian HIV/AIDS Legal Network & Eurasian Harm Reduction Association. The access of people who inject drugs to drug dependence treatment in Kazakhstan: Briefing paper. Vilnius: Eurasian Harm Reduction Association; 2018.
41. The Global Fund. 39th Board Meeting of the Global Fund. Revised Eligibility Policy. May 2018, Skopje. Geneva: The Global Fund; 2018.
42. PEPFAR. Ukraine Country Operational Plan (COP) 2017 Strategic Direction Summary. Washington: PEPFAR; 2017.
43. Global Fund Office of the Inspector General. Global Fund Grants to Ukraine - Audit Report. Geneva: The Global Fund; 2018.
44. Global Fund Advocates Network & International Civil Society Support. Investing in the Global Fund: The Cost of Inaction. Global Fund replenishment 2016. Amsterdam: International Civil Society Support; 2016.

45. Data for Impact [Internet]. [cited 2018 Jun 27]; Available from: <https://www.pepfar.gov/priorities/data/index.htm>
46. Summers T. The Global Fund and PEPFAR: Complementary, Successful, and Under Threat. Washington: CSIS Global Health Policy Center HIV Working Group; 2017.
47. PEPFAR. PEPFAR 3.0: Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation. Washington: PEPFAR; 2014.
48. WHO, UNODC & UNAIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. Geneva: World Health Organization; 2012.
49. PEPFAR. Survey response to HRI on harm reduction funding. Washington: PEPFAR; 2018.
50. Syringe Services Programs | Injection Drug Use | HIV Risk and Prevention | HIV/AIDS | CDC [Internet]. 2018 [cited 2018 Jun 27]; Available from: <https://www.cdc.gov/hiv/risk/ssps.html>
51. Data Sources [Internet]. [cited 2018 Jun 27]; Available from: <https://data.pepfar.net/dataSources>
52. FY 2016 PEPFAR Country Operational Plan Sustainability Indices and Dashboards (SIDs) [Internet]. [cited 2018 Jun 27]; Available from: <https://www.pepfar.gov/countries/cop/c71524.htm>
53. Csete J, Gathumbi A, Wolfe D, Cohen J. Lives to save: PEPFAR, HIV, and injecting drug use in Africa. *The Lancet*, Volume 373, No. 9680, p2006–2007, 13 June 2009.
54. amfAR. Is PEPFAR Funding for Key Populations Aligned with the Epidemiologic Burden? Washington: amfAR; 2016.
55. PEPFAR. Comprehensive HIV Prevention for People Who Inject Drugs, Revised Guidance. Washington: PEPFAR; 2010.
56. United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, United States Agency for International Development. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017.
57. US Department Of State. PEPFAR: Key Populations [Internet]. [cited 2018 Jun 27]; Available from: <http://www.pepfar.gov/press/262036.htm>
58. Harm Reduction International. Harm reduction funding situation in Indonesia: Research for HRI with the Harm Reduction Advocacy in Asia project. pre-published.
59. AIDS Research Center Atma Jaya Catholic University of Indonesia. Integrated Biological and Behavioral Surveillance on HIV, Hepatitis B, Hepatitis C and Syphilis Transmission Among Meth-Users Population in Six Cities of Indonesia. Jakarta: Atma Jaya Catholic University of Indonesia; 2017.
60. Stoicescu C. Women speak out: Understanding women who inject drugs in Indonesia. Jakarta: PKNI, Indonesian Drug Users Network; 2018.
61. Institute for Health Metrics and Evaluation, University of Washington. Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda. Washington: University of Washington; 2018.
62. Badan Narkotika Nasional Indonesia. Laporan Kinerja Badan Narkotika Nasional untuk Tahun Anggaran. Jakarta: Government of Indonesia; 2018.
63. The Vietnam Administration for HIV/AIDS Control, UNAIDS, World Bank, University of New South Wales. Evaluation of the epidemiological impact of harm reduction programs on HIV in Vietnam. Washington: World Bank; 2010.
64. Zhang L, Maher L, Pham QD, Higgs P et al. Evaluation of a decade of DFID and World Bank supported HIV and AIDS programmes in Vietnam from 2003 to 2012. Sydney: University of New South Wales; 2013.
65. PEPFAR. Vietnam Country Operational Plan (COP/ROP) 2017 Strategic Direction Summary. Washington: PEPFAR; 2017.
66. Vuong T, Ritter A, Shanahan M, Ali R, Nguyen N, Pham K, et al. Outcomes of compulsory detention compared to community-based voluntary methadone maintenance treatment in Vietnam. *J Subst Abuse Treat* 2018;87:9–15.

-
67. Funders concerned about AIDS. Philanthropic Support to Address HIV/AIDS in 2016: Reignite the fight. Washington: Funders concerned about AIDS; 2017.
 68. Personal communication with Funders Concerned About AIDS. 2018.
 69. HIV [Internet]. Bill Melinda Gates Found. [cited 2018 Jun 27]; Available from: <https://www.gatesfoundation.org/What-We-Do/Global-Health/HIV>
 70. Personal communication with UNAIDS. 2018.





HARM REDUCTION INTERNATIONAL

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights-based approaches to drug policy through an integrated programme of research, analysis, advocacy and partnerships. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

www.hri.global