

Harm reduction investment assessment tool:

A step-by-step guide

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HARM REDUCTION
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A step-by-step guide

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Harm Reduction International (HRI) is a leading non-governmental organisation dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

HRI would like to acknowledge Lei Zhang for his work in designing an earlier version of this tool in 2013.

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Harm Reduction expenditure assessment tool: Part 1

Why is the tool needed?

Harm reduction programmes in many low- and middle-income countries are overly reliant on international donors for sources of funding. To ensure the sustainability of services, there is an urgent need for increased national government investment in harm reduction approaches. The tracking of international and national investment in harm reduction is essential to inform advocacy for increased resources for harm reduction. This information is challenging to gather as most donors and governments do not record or disaggregate their budgets in a way that is useful for monitoring harm reduction spending.

HRI worked with researchers, civil society and community experts to design accessible tools for assessing the state of harm reduction funding situations at country level. This tool, originally designed in 2013, has been used by harm reduction advocates to assess harm reduction investment in several countries in Asia and the European Union, as well as the Middle East and North Africa.

Part 1 of the Harm Reduction Investment Assessment tool provides a template for assessing expenditure on priority harm reduction interventions. Part 2 is a set of questions for key stakeholders designed to provide contextual information on the sustainability of harm reduction financing at country level.

Please find Part 1 of the Harm Reduction Investment Assessment tool at: www.hri.global/tools-for-advocates.

This section provides step-by-step guidance for using Part 1 of the Harm Reduction Investment Assessment tool.

What are the key questions?

This tool is designed to capture and estimate national spending on harm reduction programmes and antiretroviral treatment for people who use drugs (Figure 1). It aims to answer a number of key questions:

- What is the level and source(s) of current financial investments in harm reduction programming within the country?
- How is this money being spent? To what extent does funding go towards priority interventions such as needle and syringe programmes, opioid substitution therapy and antiretroviral treatment for people who use drugs?
- To what extent does this funding come from government and/or international donor

sources?

What is the approach?

This section details the steps civil society researchers should take to gather information on the current state of harm reduction funding in their country. The methodology includes a comprehensive list of indicators and provides various options for collecting relevant costing data from different information sources in selected countries, for example, survey and literature review. The assessment tool will provide an evidence base to inform harm reduction resourcing advocacy, to include calling for strategic investment, reinvestment of funds away from punitive measures towards harm reduction approaches and the better disaggregation of government and donor budgets to facilitate the tracking of harm reduction spend.

How is the tool structured?

The tracking tool consists of five spreadsheets. The first two worksheets are the title page and

Assessing harm reduction investment - Part 1	
An investment tracking tool to assess expenditure on harm reduction programmes for people who use drugs	
In 2014, Harm reduction International (HRI) commissioned the Kirby Institute, University of New South Wales to develop an investment tracking tool to assess harm reduction expenditure. This is an updated version incorporating feedback from researchers in several countries in Asia and Europe who have used the tool.	
Country Name	
Researcher name	
Date	
<p>Objective: This tool is designed to capture and estimate expenditure on harm reduction programmes for people who use drugs over the course of three consecutive years.</p> <p>This tool consists of three major components: (detailed instructions are provided in each work sheet and in the accompanying manual)</p> <ol style="list-style-type: none"> 1. Opioid Substitution Therapy (OST) 2. Needle and Syringe Programme (NSP) 3. Antiretroviral Treatment (ART) 	

Figure 1 – Title page of the investment assessment tool

The definition worksheet provides a comprehensive reference list for all studied populations, interventions and drug-related activities. The definitions are adapted from well-recognised international sources^{1,2,3} (Figure 2).

DEFINITIONS	
Definition for key population	
Population	Definition
People who use drugs	People who use drugs in the past 12 months prior to survey
People who inject drugs	People who have injected drugs in the past 12 months prior to survey
People living with HIV	People who have an HIV positive diagnosis through qualified screening and confirmatory tests
Definitions of OST Activities	
Activity (Service provided to OST recipients)	Definition
Information, Education and Communication (IEC)	An operational definition of "IEC" refers to a public health approach aiming at changing or reinforcing health-related behaviours in a target audience, concerning a specific behaviour and within a pre-defined period of time, through communication methods and principles
Provision of methadone or buprenorphine	Daily provision/dispensing of medication (liquid or powdered).
Take-home dosing	When dose of medication for several days is given to client at one time to reduce need for daily visit.
Short-term off-site dosing services	To deliver appropriate dose of medication at home, or at hospital due to health condition of an OST client. For hospital stays, etc.
Case management	Management of individual cases by social worker, to improve the outcome of a treatment, assist with employment, housing etc.
Regular clinical assessments	Performed by doctor to monitor health condition of a client.
HIV test and pre- and post- test counselling	Administering of HIV test and pre and post test counselling with a trained person (medical professional or other).
Group sessions and support groups	Includes organization of group sessions, couples therapy, motivational interviewing, enhancement of motivation, family therapy and etc.
TB screening and diagnosis	Provision of a TB screening with relevant lab. controlled assessments, including X-ray examinations prescribed and performed by medical doctor for early detection of TB infection and future management. For PLHIV, standard screening should be with GeneXpert rather than clinical screening
TB DOTS	Dispensing TB medication and other activities to assure TB treatment adherence
Overdose prevention	Must distribute Naloxone with relevant information - how and when to use
STI diagnosis	This means provision of STI tests with relevant lab. controlled assessments prescribed and performed by infectious diseases specialist. Includes syndromic diagnosis (in use in some countries) and lab-based diagnosis.
STI treatment	Provision of STI treatment by trained medical professional
Gender-sensitive services for women	Services specifically provided to women and families, including gynaecological exams, pregnancy test, providing hygienic materials and food, and consultation of paediatrician.
Social work and counselling	Includes counselling for risk reduction and referral to treatments, ART-therapy counselling, social assistance. Does not include legal services.
Vocational training	Training for OST recipients to have specific skills. For example, building of computer skills.
Condom and informational material distribution	Giving OST recipients condoms and informational materials, such as pamphlets

Figure 2 – A list of definitions of key populations and drug intervention activities

The following three worksheets provide templates for the collection of spending data on opioid substitution therapy (OST) programmes, needle and syringe programmes (NSP) and antiretroviral treatment (ART), respectively (Figure 3). All three templates are laid out in a similar format, although the detailed breakdown of cost items varies across different programmes.

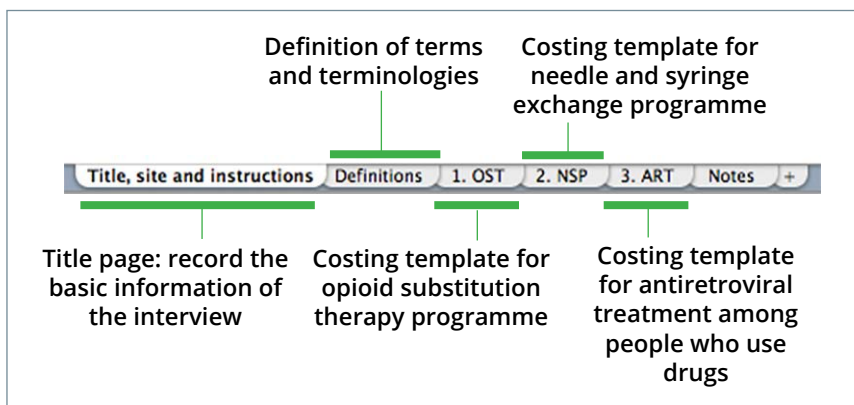


Figure 3 – Structure of the investment assessment tool

How to collect costing data

Since all three costing templates share a similar structure and layout, we use the OST spreadsheet as a demonstration for the process of data collection. In brief, the template consists of two components: general information on people who use drugs, coverage of the specific programme in the studied country, and options for cost collection. Notably, colour-coded cells represent essential information required for the desired outcomes and are

Colour codes:

	Compulsory information required for subsequent calculation
	Compulsory outcome values

Figure 4 – Compulsory colour-coded cells

1. General information

The general information in the OST template includes: 1) the total number of OST clinics nationwide; 2) the number of people who use drugs enrolled in OST; 3) coverage of OST among people who use drugs and 4) the percentage of contribution of international funders (Figure 5). Each item has explanatory notes to explain its calculation. The duration of data collection is three years (years to be amended by researcher as required). The NSP and ART templates include similar indicators for their own programmes.

General information

Items	Notes	2018	2019	2020
Total number of OST clinics nationwide	Data source:			
Number of people enrolled in OST programme nationwide	Data source:			
Coverage of OST nationwide	Numerator: the number of people enrolled in OST programme; Denominator: the estimated size of opioid-using population, or if not available, estimated number of people who inject drugs. Data source:			
Contribution of international funding sources (%)	Data source:			
Specific international donor spend (%)	Data source:			

Figure 5 – General information on people who use drugs and OST programmes are mandatory

2. Cost information

It is important to remember that lack or absence of funding data is in itself an interesting finding, and that inevitably there will be gaps in data available. Crucially, this tool provides researchers with options for data collection to cater for differences and gaps in the available information. The four options provided are designed to accommodate different data sources and circumstances. They are also designed to capture the overall spending of the programmes based on a ‘top-down’ approach, where cost data are collected at the national level rather than from individual programme sites.

OPTION 1: Provide an estimate of the national spending only

This option is provided when the information available on programme spending is minimal. The researcher is only able to obtain an estimate of the overall spending at the national level without data sources for further breakdowns. The figure can be provided by a key stakeholder through a quick reference to a past published or internal country report. Notably, it is important to indicate whether the total spending comes from domestic sources only, international sources only or both and wherever possible include the source of funding. In combination with the estimated percentage of the international contribution in the ‘general information’ table, the overall national programme spending can be estimated.

Cost information

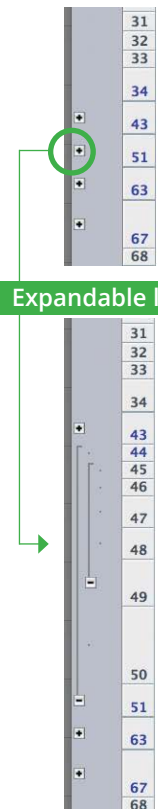
1. Provide total programme spending at the national level

Indicate the source of spending:		Both domestic and international		
Items	Notes	2015	2016	2017
National spending on OST (USD)	Indicate if spending is Domestic or International or Sum of both (drop-down list)			

Figure 6 – Provide an estimate of overall national programme spending

OPTION 2: Provide an estimate of national spending with breakdowns

This option enables the provision of detailed cost break-down of the programme. The four main categories are 1) staffing cost; 2) commodity and equipment costs; 3) overhead costs and 4) costs for monitoring and evaluation. For each of these categories, the researcher has the option to insert a categorical sum or breakdowns for further sub-items (Figure 7). The national spending will be calculated as the sum of all categories. This option is most suitable for the circumstance where the researcher has good access to detailed cost data from key stakeholders in the government or programme management.



2. Provide programme spending with breakdowns at the national level

Indicate the source of spending: **Not selected**

Items	Notes	2015	2016	2017
1. Staffing Costs for OST	Provide a categorical spending OR sum spending of item breakdowns			
2. Commodities & Equipment Costs	Provide a categorical spending OR sum spending of item breakdowns			
3. Overhead Costs	Provide a categorical spending OR sum spending of item breakdowns			
4. Monitoring and evaluation	Provide a categorical spending OR sum spending of item breakdowns			
National spending on OST (USD)	Sum from categorical spending; Indicate if spending is Domestic or International or Sum of both (drop-down list)			

2. Provide programme spending with breakdowns at the national level

Indicate the source of spending: **Not selected**

Items	Notes	2015	2016	2017
1. Staffing Costs for OST	Provide a categorical spending OR sum spending of item breakdowns			
2. Commodities & Equipment Costs	Provide a categorical spending OR sum spending of item breakdowns			
2.1. Cost of provision of OST				
2.1.1. Methadone/Buprenorphine	Methadone/Buprenorphine and containers			
2.1.2. Urine tests	Cost of urine tests and containers			
2.1.3. HIV/STIs/TB tests	HIV screening tests, tests for sexually-transmitted infections, Tuberculosis screening tests			
2.1.4. Gloves, reagents and laboratory supplies	Naloxone, naltrexone, antidepressants, condoms, lubricants and any other laboratory tests			
2.2. Medical Equipment	Fridge, dosimeters, BP monitor, mechanical pipettes, triplet furniture, lab furniture, water distillation machine, water dispenser, scales weight			
2.3. Non-medical Equipment	Computers, printers, scanners, Faxes, Shredder, tables, chairs, bookshelves, filing cabinet, nightstand, safe/strongbox, wardrobe, vehicles, air conditioner, heating appliance, power supply, camera, video recorder, cable channel connector			
3. Overhead Costs	Provide a categorical spending OR sum spending of item breakdowns			
4. Monitoring and evaluation	Provide a categorical spending OR sum spending of item breakdowns			
National spending on OST (USD)	Sum from categorical spending; Indicate if spending is Domestic or International or Sum of both (drop-down list)			

Figure 7 – Demonstration of the expandable list for collecting cost break-down data at the national level

OPTION 3: Provide programme investment funded by individual projects

This option enables data collection on multiple funding/project sources. The same programmes (e.g. OST) can be funded through multiple channels, including the domestic government, multiple international organisations and the private sector. This is often common in settings where local jurisdictions are given the autonomy to attract various funding sources for their own programmes and international donors play a major role in harm reduction for people who use drugs in the country. This option only requires a single overall spending estimate and the recorded number of people who use drugs covered by the funded programme from each individual project. This information is often readily available from annual reports required and published by donors, based on which, per-capita investment per person using drugs from all projects can be obtained. The national spending can then be estimated by multiplying the per-capita amount to the total number of people who use drugs linked to the programme nationally. Also, if projects are able to provide further categorical cost breakdowns, this would be a bonus. If there are more than 5 projects identified, please include further items in accordance with your needs.

3. Provide programme spending supported by particular projects

Items		2015	2016	2017
Project 1				
Amount invested on OST by Project 1	Provide total spending on OST by Project 1			
Number of people received OST through Project 1	The number of people who access OST through Project 1 in the past 12 months			
Project 2				
Amount invested on OST by Project 2	Provide total spending on OST by Project 2			
Number of people received OST through Project 2	The number of people who access OST through Project 2 in the past 12 months			
Project 3				
Amount invested on OST by Project 3	Provide total spending on OST by Project 3			
Number of people received OST through Project 3	The number of people who access OST through Project 3 in the past 12 months			
Project 4				
Amount invested on OST by Project 4	Provide total spending on OST by Project 4			
Number of people received OST through Project 4	The number of people who access OST through Project 4 in the past 12 months			
Project 5				
Amount invested on OST by Project 5	Provide total spending on OST by Project 5			
Number of people received OST through Project 5	The number of people who access OST through Project 5 in the past 12 months			
Total investment on OST by all projects	Sum OST spending from all projects			
Total number of people received OST through projects	Sum the number of people receiving OST covered by all projects			
Per-capita investment on OST	Divide the total OST spending by the number of people accessing OST through these projects			
National spending on OST (estimated, USD)	Multiply the per-capita OST investment to the total number of drug users covered by the national OST programme			

Figure 8 – Estimating the national spending based on spending on individual projects

OPTION 4: Survey programme spending based on a single programme site

Option 4 is a 'back-up' option if all above options fail. This option requires the researcher to physically survey costing data from a single programme site. The layout of the table and breakdown of cost are identical to those of the Option 2. The estimated cost is then multiplied to the total number of programme sites nationwide to provide the national spending of the programme. Since only one programme site is surveyed, the anticipated bias and uncertainty of the estimate is likely to be significant.

4. Provide programme spending with breakdowns for ONE OST clinic

Items		2015	2016	2017
1. Staffing Costs for OST	Provide a categorical spending OR sum spending of item breakdowns			
2. Commodities & Equipment Costs	Provide a categorical spending OR sum spending of item breakdowns			
3. Overhead Costs	Provide a categorical spending OR sum spending of item breakdowns			
4. Monitoring and evaluation	Provide a categorical spending OR sum spending of item breakdowns			
Total spending in ONE OST clinic	Sum from categorical spending			
National spending on OST (estimated, USD)	Multiply the spending in one OST clinic to the total number of OST clinics in the country			

Figure 9 – Estimating national spending based on a survey at a single programme site

Harm reduction investment assessment tool: Part 2

This part of the harm reduction investment assessment tool provides a framework for gathering contextual information through desk-based research and surveying key stakeholders from civil society and community organisations, donors and government. Alongside the financial evidence gathered using Part 1, this information is important for informing advocacy for improved harm reduction investment at local and/or national level.

Recommendations for use

- The questions are designed to capture information on the health of harm reduction funding in a country. They should be answered by a researcher following desk-based research and interviews with key stakeholders from community and civil society organisations, government and donors.
- The questionnaire should serve as a basis for interviews with stakeholders, but not all questions will be relevant for all, so researchers should tailor their interviews accordingly.
- Researchers should ensure that interviewees sign an Informed Consent Sheet prior to being interviewed. They should be made aware of the intended use of information provided, including any plans for publications. Researchers should only use quotes with interviewee agreement and if the information in the quote poses no threat to their anonymity. There should be agreement made on how individuals are to be identified, e.g. representative of network of people who use drugs, government etc.
- Researchers should make every effort to gather references from interviewees when they provide data. This will be important for including data in any publication and for advocacy.
- Reference documents should be saved. These could be in English or local languages and could include national plans, strategies and budgets, published and grey literature, and legal documents.
- In many countries, there are gaps in the available information on harm reduction funding. It is likely that some data will not be possible to obtain. Recording information gaps is an important part of this research. If no data are available to answer a particular question, researchers should provide some details on why this is, rather than leaving the question blank.

Theme 1: Overall state of harm reduction funding

1. Is there a recent (published in the past 5 years) national population size estimate of people who inject drugs and/or people who use drugs? If so, what is the estimate (please provide reference document)? Is this considered to be accurate by key stakeholders?
2. Is there a national strategic plan that includes harm reduction? Is there a defined budget for the plan? (please retain for records, if available)
 - a. Does the national strategic plan refer to particular groups of people who use drugs, such as women and transgender populations who use drugs, people in prison, or those living in rural communities?
 - b. Does the defined budget for the plan allocate funds specifically for particular groups?
3. Is there a readily available source for data on harm reduction funding in your country? If so, please provide details.
4. How much money was spent on harm reduction in your country in 20XX (most recent year available)?
5. What were the sources of this funding (e.g. government department/ministry, private sector, international donor)?
6. What percentage did each source contribute over the time period? (please use the below table as guidance)

Source of funding for harm reduction services	Year 1	Year 2	Year 3 (most recent available)
International donor (please add rows for multiple donors)			
Government (please add rows for multiple government departments)			
Private sector (please add rows for multiple private companies)			

7. Are harm reduction services adequately funded in your country? Please check whether harm reduction resource needs and funding gaps have been studied in the past five years in your country (retain research papers, if available). Please provide information on programming areas that require more funding. This could be a particular intervention, a geographical area, or a group of people who use drugs that are underserved by current programmes.

Theme 2: Source and distribution of harm reduction funds

- 8.** What harm reduction services and interventions are available for people who use drugs (both injecting and non-injecting) in your country? Please add other interventions if they are not listed below.
- a.** Needle and syringe programmes (NSP)
 - b.** Opioid substitution therapy (OST)
 - c.** HIV testing and counselling
 - d.** Antiretroviral therapy (ART)
 - e.** Prevention and treatment of sexually transmitted infections (STIs)
 - f.** Condom programmes for people who use drugs and their sexual partners
 - g.** Targeted information, education and communication for people who use drugs and their sexual partners (please stipulate the forms these IEC take, e.g. pamphlets)
 - h.** Vaccination, diagnosis and treatment of viral hepatitis
 - i.** Prevention, diagnosis and treatment of tuberculosis
 - j.** Harm reduction for people who use stimulants (please provide details)
 - k.** Overdose prevention (please state whether naloxone is available and if so, whether it is distributed to people who use drugs)
 - l.** Legal aid assistance
 - m.** Psychosocial support services
 - n.** Couples HIV counselling
 - o.** Drug consumption rooms
 - p.** Other (please provide details)
- 9.** How many people were reached by the following harm reduction services in 20XX (most recent year available)? If no estimate is available, please provide an estimate of the coverage of these programmes. Please also provide any information available on who is accessing services (e.g. gender, age).
- a.** Needle and syringe programmes (NSP)
 - b.** Opioid substitution therapy (OST)
 - c.** HIV testing and counselling
 - d.** Antiretroviral therapy (ART)
 - e.** Prevention and treatment of sexually transmitted infections (STIs)
 - f.** Condom programmes for people who use drugs and their sexual partners
 - g.** Targeted information, education and communication for people who use drugs and their sexual partners
 - h.** Vaccination, diagnosis and treatment of viral hepatitis
 - i.** Prevention, diagnosis and treatment of tuberculosis

- j.** Harm reduction for people who use stimulants (please provide details)
 - k.** Overdose prevention (please state whether naloxone is available and if so, whether it is peer distribution)
 - l.** Legal aid assistance
 - m.** Psychosocial support services
 - n.** Couples HIV counselling
 - o.** Drug consumption rooms
 - p.** Other (please provide details)
- 10.** Which international donors currently fund harm reduction in your country? Please provide details.
 - 11.** How much money was invested in needle and syringe programmes in 20XX (most recent available year)? What percentage of this was national government funding?
 - 12.** How much money was invested in opioid substitution therapy in 20XX (most recent available year)? What percentage of this was national government funding?
 - 13.** How much money was invested in antiretroviral therapy for people who use drugs in 20XX (most recent available year)? What percentage of this was national government funding?
 - 14.** How much was spent on harm reduction for people who use stimulants in 20XX (most recent available year)? What percentage of this was national government funding?
 - 15.** Please provide any information you have on spending relating to other harm reduction interventions within your country (refer back to the list you completed in question 8).
 - 16.** Have unit costs of delivering harm reduction services been calculated in your country context? If so, please provide details on unit costs, how these have been calculated and what they encompass.
 - 17.** Is there an available estimate of 'out of pocket' expenses of people who use drugs within your country? If not, please provide any information you have on the spending of people who use drugs to cover their own harm reduction costs (for example, purchasing sterile injecting equipment).
 - 18.** How much money was spent on HIV prevention in your country in 20XX (most recent available year)? What percentage was covered by national government funding?
 - 19.** Which harm reduction initiatives are available within prisons?
 - 20.** To what extent are the services available to prisoners? Please give any available information to provide an indication of service coverage, for example, NSP is available in 4 out of 20 prisons in the country, or 430 prisoners were receiving OST in 20XX, out of a total of 5,600 prisoners in the country.
 - 21.** Which government department holds the budget for prison harm reduction services?
 - 22.** How much was spent on harm reduction services within prisons in 20XX (most recent year available)? Please specify amounts spent on different interventions where possible.

- 23.** What is the source of funding for harm reduction services within prisons and what percentage did each source contribute over the time period? Please use the table below as guidance.

Source of funding for harm reduction services within prison settings	Year 1	Year 2	Year 3 (most recent available)
International donor (please add rows for multiple donors)			
Government (please add rows for multiple government departments)			
Private sector (please add rows for multiple private companies)			

- 24.** How much of the prison health budget was directed to harm reduction in 20XX (most recent year available).

Theme 3: Funding gaps, challenges and trends

- 25.** Has there been a change in drug use in your country over the last three years?
- Has there been an increase in the use and/or injecting of amphetamine-type stimulants?
 - Has there been a decrease in heroin use and/or injecting?
- 26.** Has harm reduction funding in your country increased, decreased or stayed the same over the last three years?
- If it has changed, has it reflected the changes in the situation of drug use in your country as stated above?
 - What has been the impact of this funding change had on harm reduction service provision and on the health of people who use drugs in your country?
- 27.** If funding for harm reduction from an international donor has recently reduced or ceased in your country, has this funding gap been covered by other sources? If so, how has this gap been covered, and by whom?
- If there has been a transition from international donor funding for harm reduction to national government support, how well has this transition been managed?
 - How could this process have been better managed to ensure sustainable harm reduction funding?
- 28.** What are the biggest barriers for securing government funding for harm reduction in your country?

29. What are the biggest enablers for securing government funding for harm reduction in your country?
30. What are the current processes involved in accessing available funds? Applications to government? Other sources of funding?
31. Based on the available evidence, does the national government have the political will to sustain investment in harm reduction for the next 5 years? Why or why not? Please include details of any commitments the government has made in relation to future harm reduction funding.
32. Is there a current or future role for private sector companies in supporting harm reduction in your country? If already in place, please provide details on the quality and scope of the services supported by the private sector.
33. Do you have other suggestions on how funding for harm reduction programmes in your country may be sustainable in the long term (over the next 5 to 10 years)?

Theme 4: Advocacy for harm reduction investment

34. How much funding is available for civil society and community advocacy in the country? What are the sources of this funding?
35. How are harm reduction funding allocations decided at the national level? How are these funds distributed at the local/provincial level? Are civil society organisations engaged in decision-making processes relating to funding allocations?
36. Are civil society organisations involved in advocating for harm reduction investment in your country? Is there a need for increased capacity in this area?
37. Please describe any successful examples of harm reduction funding advocacy in your country.
38. If harm reduction funding advocacy has not been successful, what have the major barriers been?
39. The harm reduction community is calling for governments to redirect spending towards health and harm reduction and away from punitive policing and incarceration of people who use drugs (see www.hri.global/10by20). To what extent does the national government invest in punitive drug policy measures in your country? For example, how much is spent on drug law enforcement or incarceration of people who use drugs?

Theme 5: The state of harm reduction at-a-glance

40. Based on the information you have collected, how would you rate the national harm reduction funding situation according to the parameters in Table 1 below? Green indicates a positive funding situation, amber represents a moderate situation with some level of funding uncertainty, and red indicates a precarious and highly challenging funding situation. Please indicate green, amber or red for each factor below and provide clarifications and references for your ratings. Please note when considering 'harm reduction coverage' that the extent to which other harm reduction services are available should also be considered, particularly if the majority of people who use drugs would not benefit from NSP or OST (i.e. do not inject opiates).

- a. Harm reduction coverage
- b. Availability of expenditure data
- c. Government investment in harm reduction
- d. Civil society representatives' view on sustainability of funding

Table 1: Criteria for establishing national harm reduction funding situation

Factor	Green	Amber	Red
Harm reduction coverage	Both NSP and OST operating at recommended coverage levels	Either NSP or OST operating at recommended coverage levels	Neither NSP or OST operating at recommended coverage levels
Availability of expenditure data	Spending information routinely collected and made available in a transparent manner	Partial spending information available	Spending information unavailable
Government investment in harm reduction	Overall government investment is high and government provides over 90% of harm reduction funding	Government investment is moderate, either proportionally (e.g. government provides between 50% – 90% of HR funding) or as an overall amount	Government investment is low, either proportionally (e.g. government provides less than 50% of harm reduction funding) or as an overall amount
Civil society representatives' view on sustainability of funding	Funding judged to be secure for next 5 years	Some uncertainty around funding levels and anticipated reductions in the next 5 years	Funding for harm reduction extremely low, or serious funding cuts anticipated in the next 5 years



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.