

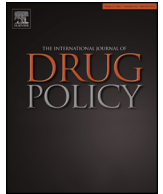


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Research paper

The Global Fund to Fight AIDS, Tuberculosis and Malaria's investments in harm reduction through the rounds-based funding model (2002–2014)

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ABSTRACT

Background: Harm reduction is an evidence-based, effective response to HIV transmission and other harms faced by people who inject drugs, and is explicitly supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In spite of this, people who inject drugs continue to have poor and inequitable access to these services and face widespread stigma and discrimination. In 2013, the Global Fund launched a new funding model—signalling the end of the previous rounds-based model that had operated since its founding in 2002. This study updates previous analyses to assess Global Fund investments in harm reduction interventions for the duration of the rounds-based model, from 2002 to 2014.

Methods: Global Fund HIV and TB/HIV grant documents from 2002 to 2014 were reviewed to identify grants that contained activities for people who inject drugs. Data were collected from detailed grant budgets, and relevant budget lines were recorded and analysed to determine the resources allocated to different interventions that were specifically targeted at people who inject drugs.

Results: 151 grants for 58 countries, plus one regional proposal, contained activities targeting people who inject drugs—for a total investment of US\$ 620 million. Two-thirds of this budgeted amount was for interventions in the “comprehensive package” defined by the United Nations. 91% of the identified amount was for Eastern Europe and Asia.

Conclusion: This study represents an updated, comprehensive assessment of Global Fund investments in harm reduction from its founding (2002) until the start of the new funding model (2014). It also highlights the overall shortfall of harm reduction funding, with the estimated global need being US\$ 2.3 billion for harm reduction in 2015 alone. Using this baseline, the Global Fund must carefully monitor its new funding model and ensure that investments in harm reduction are maintained or scaled-up. There are widespread concerns regarding the withdrawal from middle-income countries where harm reduction remains essential and unfunded through other sources: for example, 15% of the identified investments were for countries which are now ineligible for Global Fund support.

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Introduction

Harm reduction – broadly defined as “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption” (Harm Reduction International, 2011) – is a proven, effective

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Box 1. The United Nations “comprehensive package” (WHO, 2012)

1. Needle and syringe programmes
2. Opioid substitution therapy and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom distribution programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

and cost-effective approach for people who use drugs, and especially for preventing the transmission of HIV, viral hepatitis, tuberculosis and other harms among people who inject drugs. The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) have elaborated and endorsed a “comprehensive” package of nine harm reduction interventions for people who inject drugs (Box 1) – stating that delivery of the whole package is key, but that “countries should prioritise implementing NSPs [needle and syringe programmes] and evidence-based drug dependence treatment (specifically OST [opioid substitution therapy])” (WHO, UNODC, & UNAIDS, 2012).

Other international partners have expanded on this package defined by the United Nations. For example, the United States President’s Emergency Plan for AIDS Relief (PEPFAR) adds community-based outreach to the list (PEPFAR, 2010); the International HIV/AIDS Alliance has outlined a package of 15 interventions including overdose prevention, advocacy, psychosocial support, and legal support (International HIV/AIDS Alliance, 2010); and the International Drug Policy Consortium (IDPC) also includes drug consumption rooms/safer injecting facilities (IDPC, 2012).

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is the leading international donor for harm reduction services (Bridge, Hunter, Atun, & Lazarus, 2012). Founded in 2002, the Global Fund is a partnership between governments, civil society, the private sector and affected populations. It raises and invests nearly US\$ 4 billion each year for programmes, and works in line with three core principles: partnerships, country ownership and performance-based funding – meaning that local partners implement programmes based on the specific priorities in each country, and the Global Fund provides financing on the condition that verifiable results are achieved.

From 2002 until 2013, the Global Fund operated via a ‘rounds-based model’ whereby proposals from eligible countries or regional bodies were developed and submitted during designated funding windows, with guidance from the Global Fund and its partners. Once submitted, proposals were reviewed by an independent Technical Review Panel, which then made funding recommendations to the Global Fund Board. Successful proposals in each ‘round’ were approved for 2 years (“Phase 1”), after which a review of progress, results and impact was conducted before continued funding was approved for the next three years (“Phase 2”). Some grants from Round 1 (2002) to Round 5 (2005) were also invited to apply for a further two three-year periods of funding known as the “Rolling Continuation Channel” (this mechanism was discontinued after Round 5).

Since its inception, the Global Fund has encouraged applicants to include harm reduction interventions in their proposals. A series

of information notes on harm reduction, released since Round 10 (2010), make it clear that the Global Fund “supports evidence-based interventions aimed at ensuring that key populations have access to HIV prevention, treatment, care and support ... [including] the comprehensive package for the prevention, treatment and care of HIV among people who inject drugs” (Global Fund, 2010, 2011a, 2014a). In Round 10, the Global Fund also created a dedicated funding reserve for HIV proposals that focused on most-at-risk populations (which, in practice, were people who inject drugs, men who have sex with men, sex workers and transgender individuals). A similar mechanism was due to be rolled out in Round 11 (2011), but in November 2011 the Global Fund Board took the decision to replace Round 11 with a ‘Transitional Funding Mechanism’. In response to economic uncertainties at the time, this Mechanism limited proposals to the continuation (rather than scale-up or introduction) of essential services that faced disruption due to existing grants ending.

In 2012, data were released from a detailed portfolio analysis from Round 1 (2002) to Round 9 (2009) – showing that the Global Fund had invested or approved US\$ 430 million for activities that specifically targeted people who inject drugs. This total included 120 HIV grants for 55 countries and territories – and represented around 4% of the total amount approved for HIV grants during this period (Bridge et al., 2012). A subsequent analysis aimed to include data from Round 10 (2010), taking the total to US\$ 580 million (Harm Reduction International, 2012).

Despite these substantial resources from the Global Fund, the global funding for harm reduction remains woefully short of the actual needs (Harm Reduction International, International Drug Policy Consortium, International HIV/AIDS Alliance, 2014). UNODC, WHO, UNAIDS and the World Bank have jointly estimated that there are 12.7 million people who inject drugs globally, although the broad range provided (8.9–22.4 million) underlines the paucity of reliable data (UNODC, 2014). Research has consistently confirmed that people who inject drugs have poor and inequitable access to services (Mathers et al., 2010), and face widespread stigma, discrimination, marginalisation and abuse (Beyrer, Malinowska-Sempruch, Kamarulzaman, & Strathdee, 2010). In 2010, it was estimated that just 8% of people who inject drugs have access to NSPs worldwide, just 8% of people who inject opiates have access to OST, and just 4% of eligible people who inject drugs have access to antiretroviral therapy (ART) (Mathers et al., 2010). Updated global coverage data is urgently needed.

In February 2013, the Global Fund announced a new funding model – moving away from its rounds-based, competitive approach to “invest more strategically, achieve greater impact, and engage implementers and partners more effectively” (Global Fund, 2013). Under this new model, the Global Fund determines funding allocations for each eligible country based on calculations of country income and national disease burden. Additional funding has also been set aside for regional proposals. This article employs the same methodology from previous analyses of Global Fund investments in harm reduction (Bridge et al., 2012), thus providing a complete dataset for the entire duration of the Global Fund’s rounds-based funding model – from Round 1 (2002) to the Transitional Funding Mechanism that replaced Round 11 (2011).

Methods

The methodology for this Global Fund portfolio analysis has been outlined in greater detail elsewhere (Bridge et al., 2012). Specifically, this study focused on analysing budget data from applicable Round 10 (2010) and Transitional Funding Mechanism (2011) grants, alongside “Phase 2’s” and other grant extensions from earlier rounds for which the final budgets were unavailable

previously – therefore removing the need for the investment projections as in the previous analysis, and providing the most complete available dataset up to the end of 2014.

Relevant HIV grants were identified by searching grant proposal documents (which are publicly available from <http://portfolio.theglobalfund.org>) for nine key terms: buprenorphine, harm, IDU [injecting drug use/user], inject, methadone, needle, substitution, syringe and user.

For applicable grants, the final detailed budgets were retrieved from internal Global Fund databases and with the support of Global Fund grant management staff. These Microsoft Excel documents are the result of extensive review and negotiation between the Global Fund Secretariat and the applicant, and therefore provide the most detailed source of financial data for a grant – including all planned expenditures and projected costs. These budgets are not made publicly available due to the sensitivity of some of the information that they contain (such as staff salaries and procurement costs).

The relevant budget documents were examined line-by-line for activities that targeted people who inject drugs. For activities that target multiple most-at-risk populations including people who inject drugs, budget data were apportioned equally between each group: for example, if US\$ 200,000 was budgeted for “condoms for sex workers and people who inject drugs”, then US\$ 100,000 was included in this analysis. Activities targeting the general population were excluded, as were program management costs (such as overheads, management fees, infrastructure costs, etc.) unless they could be specifically linked to services for people who inject drugs or the entire grant targeted people who inject drugs. Relevant budget lines were recorded and coded according to 16 categories (Box 2). Where necessary, the nature of activities was clarified using other available grant documents. Data were collated and analysed using Microsoft Excel. Budget data in currencies other than US\$ were converted using an online currency converter (www.xe.com), based on the exchange rate from when the grant started. Grant documents in languages other than English were translated by multilingual staff at IDPC.

Across this and the previous analysis, a random sample of 16 grants spanning all the examined funding rounds (and representing approximately one-sixth of the total harm reduction investments identified through this analysis) were cross-checked between the lead researchers (Jamie Bridge and Benjamin Hunter). Small discrepancies or variations were identified for some of these cross-checked grants (accounting for 1.05% of the budgeted totals), and amendments made where required following discussion amongst the research team.

Limitations

The methodology for this study carries certain notable limitations that have been described in detail elsewhere (Bridge et al., 2012). These include:

- Only HIV and TB/HIV grants were included, possibly omitting investments from other grants (such as, for example, tuberculosis grants).
- Budget lines for activities that target multiple most-at-risk populations were divided equally between each group, yet will likely not be apportioned so simply in practice. However, with the available data there was no alternative method to apportion these investments more accurately.
- Activities targeting the general population and untargeted programme management costs, although excluded from this analysis, may feasibly reach people who inject drugs. Again, with the available data there was no alternative method to apportion these investments.

Box 2. Intervention codes used in the analysis.

- Needle and syringe programmes (including equipment, staff and facilities)
- Opioid substitution therapy (including equipment, staff and facilities)
- HIV testing and counselling (including equipment, staff and facilities)*
- Antiretroviral therapy (including equipment, staff and facilities)*
- Prevention and treatment of sexually transmitted infection (including equipment, staff, facilities, specific training)*
- Condom distribution programmes (including equipment, staff, facilities, specific training)*
- Targeted information, education and communication (including overdose prevention or management)*
- Prevention, vaccination, diagnosis and treatment of viral hepatitis (including equipment, staff, facilities, specific training)*
- Prevention, diagnosis and treatment of tuberculosis (including equipment, staff, facilities, specific training)*
- Building enabling supportive environments (including stigma reduction, advocacy, sensitisation, etc.)*
- Monitoring and evaluation, and research*
- Program management (such as overheads, management fees, infrastructure costs, etc.)**
- Psychosocial support, legal aid or similar services*
- Other
- Services in, or related to, compulsory drug detention centers
- Training and capacity building (including study visits)**

*Where specifically targeted at people who inject drugs.
 ** Where specifically targeted at people who inject drugs, and when not assigned specifically to one of the activities above.

- Activities included in grant proposals and budgets may not directly translate into actual services delivered on the ground.
- Data were not adjusted for the differing costs of, for example, needles and syringes, HIV tests and treatment in different countries.

Results

After the systematic filtering process, 151 grants for 58 countries were found to incorporate specific activities for people who inject drugs – as well as one regional proposal (Table 1).

Table 1
 Countries with HIV or TB/HIV grants from the Global Fund that included interventions for people who inject drugs, 2002–2014.

Asia	Eastern Europe	Latin America
Bangladesh	Albania	Argentina
Bhutan	Armenia	Mexico
Cambodia	Azerbaijan	Paraguay
China	Belarus	Middle East & North Africa
India	Bosnia & Herzegovina	Afghanistan
Indonesia	Bulgaria	Algeria
Malaysia	Croatia	Egypt
Maldives	Estonia	Iran
Mongolia	Georgia	Jordan
Myanmar	Kazakhstan	Morocco
Nepal	Kosovo	Palestine
Pakistan	Kyrgyzstan	Syria
Philippines	Macedonia	Tunisia
Sri Lanka	Moldova	Turkey
Thailand	Montenegro	Sub-Saharan Africa
Timor-Leste	Romania	Burundi
Vietnam	Russia	Cape Verde
	Serbia	Kenya
	Tajikistan	Madagascar
	Ukraine	Mauritius
	Uzbekistan	Nigeria
		Tanzania (Zanzibar)

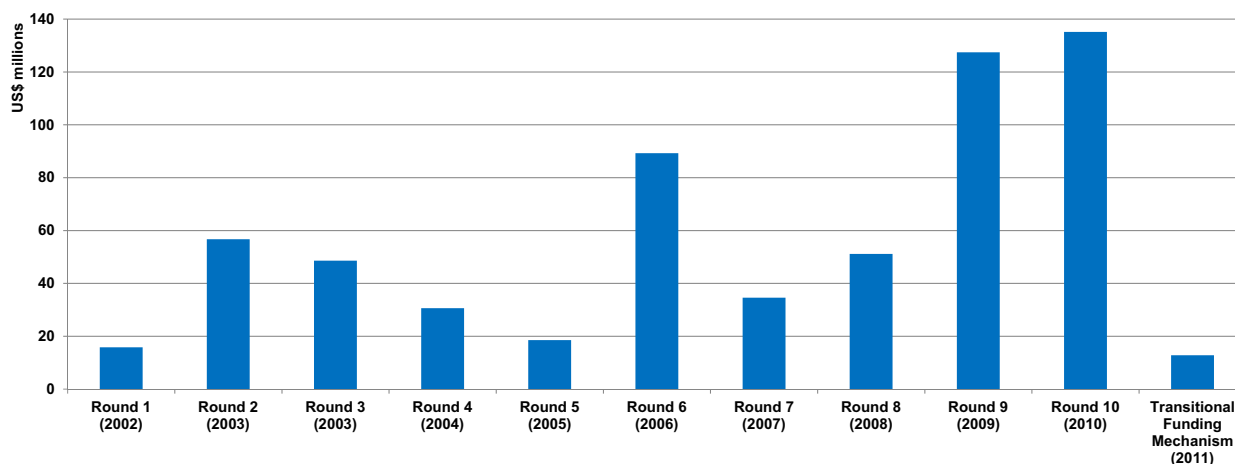


Fig. 1. Budgeted Global Fund investments for people who inject drugs, by funding round (US\$).

The signed, detailed budgets from these grants contained US\$ \$620 million for activities targeting people who inject drugs. Fig. 1 shows the distribution of investments across the funding rounds, with an upward trend between Round 7 (2007) and Round 10 (2010), followed by a sharp downturn when Round 11 (2011) was cancelled. The budgeted totals (rounded) were US\$ 16 million for Round 1 (2002), US\$ 57 million for Round 2 (2003), US\$ 49 million for Round 3 (2003), US\$ 31 million for Round 4 (2004), US\$ 19 million for Round 5 (2005), US\$ 89 million for Round 6 (2006), US\$ 35 million for Round 7 (2007), US\$ 51 million for Round 8 (2008), and US\$ 127 million for Round 9 (2009), US\$ 135 million for Round 10 (2010), and US\$ 13 million for the Transitional Funding Mechanism that replaced Round 11 (2011).

Of the 58 countries, 21 were from Eastern Europe and Central Asia, 17 were from Asia, 10 were from the Middle East and North Africa, 7 were from Sub-Saharan Africa, and 3 were from Latin America and the Caribbean. One regional proposal was for the Middle East and North Africa Harm Reduction Network (MENAHR), and covered Afghanistan, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Syria and

Table 2
Distribution of Global Fund investments for harm reduction, by intervention (US\$ millions).

Intervention	Total budgeted investment
Needle and syringe programmes	120.3
Opioid substitution therapy	103.1
HIV testing and counselling	25.0
Antiretroviral therapy	26.2
Prevention and treatment of sexually transmitted infections	12.7
Condom distribution programmes	38.0
Targeted information, education and communication	72.0
Prevention, vaccination, diagnosis and treatment of viral hepatitis	8.6
Prevention, diagnosis and treatment of tuberculosis	5.0
Building enabling supportive environments	19.2
Monitoring and evaluation, and research	27.5
Programme management	95.7
Psychosocial support, legal aid or similar services	22.8
Training and capacity building	21.7
Drug detention centres	7.7
Other	15.0
Total budgeted	620.4

Note: Figures are rounded. "Other" activities include, for example, nutritional support, primary care and first aid, and the prevention of mother-to-child HIV transmission.

Tunisia (Global Fund, 2015a). Asia and Eastern Europe accounted for 91% of the identified investments for people who inject drugs.

Table 2 shows how the investments targeting people who inject drugs were allocated between key interventions. Two-thirds of the investments were allocated to the nine interventions that comprise the United Nations' "comprehensive package" (Box 1) – with more than half of this amount going to NSP and OST, in line with the United Nations guidance to prioritise these two "drug-user-specific" interventions (WHO, 2012). A further 15% of the identified investments were for programme management and grant overheads that were targeted at people who inject drugs. The budget analysis also identified US\$ 7.7 million for interventions and activities in compulsory drug detention centres in Asia.

Discussion

Although harm reduction data from other international donors are either unavailable or not directly comparable (Harm Reduction International, 2014), the Global Fund remains a leading source of international support for harm reduction programmes. The Global Fund has invested US\$ \$620 million in activities targeting people who inject drugs from 2002 to 2014 – with the vast majority for grants in Eastern Europe and Asia. The identified investments come through 151 grants for 58 countries, as well as one regional harm reduction proposal (Table 1). The total investment identified through this analysis is an average of \$56.4 million per funding round – compared to previous findings of US\$ 47.8 million per funding round from Round 1 to Round 9 (Bridge et al., 2012), and US\$ 25.7 million per funding round from Round 1 to Round 7 (Atun & Kazatchkine, 2010).

To put these figures into perspective, between 2002 and the end of 2011 (i.e. from Round 1 to Round 10) the Global Fund had approved US\$ 12.4 billion for HIV and TB/HIV grants (Global Fund, 2012a) – followed by an additional US\$ 111.7 million under the Transitional Funding Mechanism (Global Fund, 2012b). The US\$ 620 million identified in this analysis therefore represents just under 5% of the total approved funding. Given that an estimated US\$ 2.3 billion is needed in 2015 to deliver the "comprehensive package" of harm reduction services at levels that can impact upon the epidemic (Schwartzländer et al., 2011), there clearly remains a global funding crisis for harm reduction (Harm Reduction International, 2014).

Of the budgeted US\$ 620 million, the majority (66%) was earmarked for the nine components of the "comprehensive package" (Box 1) – including US\$ 120 million for NSPs, and US\$ 103 million for OST programmes. This is in line with the United

Nations guidance, as well as the Global Fund's commitment to funding proven, cost-effective interventions. Some interventions within this package were allocated noticeably less funding in this analysis: the totals for HIV testing and counselling, antiretroviral therapy and sexually transmitted infections may well be underestimated by the methodology employed as these services are commonly delivered and budgeted at the population level, rather than targeted at specific most-at-risk populations. The low total for tuberculosis prevention, treatment and care likely reflects the decision to focus only on HIV and TB/HIV grants in this analysis. The low total for hepatitis prevention, treatment and care does seem to reflect experiences on the ground, and reflects ongoing debate and confusion as to the Global Fund's role in treating and funding services for co-infections – which has since been clarified by the Global Fund Board, who have agreed to funding co-infections and co-morbidities of HIV/AIDS, tuberculosis and malaria provided that certain criteria are met (Global Fund, 2015b).

Beyond the “comprehensive package”, around US\$ 210 million was budgeted for other activities – including critical enablers such as advocacy and sensitisation to build supportive environments (US\$ 19.2 million), psychosocial and/or legal support for people who inject drugs (US\$ 22.8 million), and training and capacity building (US\$ 15 million). The Global Fund Strategy 2012–2016 includes commitments to “Encourage and support countries to increase programming that . . . create an enabling social and policy environment” and “In the context of HIV, promote uptake of program areas identified by UNAIDS as critical enablers” (Global Fund, 2011b). Of the US\$ 620 million total investment, 15% was allocated to programme overheads – which include staffing, building costs, administration and grant management. This is in line with previous analyses (Bridge et al., 2012) and may reflect high start-up costs for these interventions in many settings.

The budget lines identified for activities within compulsory drug detention centres – such as in Cambodia, China and Vietnam – predate the Global Fund decision to cease all support for the operation of these centres. These extrajudicial centres continue to raise major human rights and public health concerns – they are associated with forced labour and torture (Human Rights Watch, 2010), they do not prevent – and likely even exacerbate – HIV transmission, and the United Nations has released a joint statement calling for their immediate closure (UNAIDS, 2012). In November 2014, the Global Fund formally committed not to finance programmes in these facilities (Global Fund, 2014b).

Looking at the harm reduction investments per funding round (Fig. 1), Round 10 (2010) continued the upward trajectory from 2007. For this round, the Global Fund created a new “MARPs Reserve” (which ring-fenced 10% of the available HIV funding for proposals that focus on most-at-risk populations), and also released their first explicit guidance on harm reduction (Global Fund, 2010). Our data indicate that these initiatives were successful: of the 32 approved HIV proposals in Round 10, 15 included some level of activity targeted at people who inject drugs, and two proposals focused entirely on this population (the regional MENAHR grant and the grant for Kazakhstan). This approach was due to be continued before the cancellation of Round 11 (2011), and should be reconsidered by the Global Fund – particularly for those countries facing reduced funding or transitioning away from Global Fund support.

The cancellation of Round 11 (2011) abruptly interrupted the upward trend in Global Fund investments for harm reduction. Several large harm reduction proposals were shelved – including one from the Eurasian Harm Reduction Network (EHRN) – and just US\$ 13 million was invested in harm reduction: a 90% drop compared to Round 10, despite the Global Fund including services targeted at people who inject drugs as one of the examples of the

“essential” services that the Transitional Funding Mechanism sought to continue (Global Fund, 2011c).

In February 2013, the Global Fund announced their new funding model based on pre-determined funding allocations that each eligible country can access over a 3-year period, rather than competitive funding rounds. Proposals still go to the Technical Review Panel, but there is also now a period of “country dialogue” between the applicant and the Global Fund Secretariat to develop their strategies. Crucially, funding allocations are made based on two main criteria: ability to pay (i.e. the country's income level as determined by the World Bank) and national disease burden.

Although the Global Fund's policy commitment to, and guidance on, harm reduction remains clear (Global Fund, 2014a), serious concerns have been raised that the new funding model poses a threat to harm reduction investments (Harm Reduction International, 2014). According to the latest eligibility list provided by the Global Fund (Global Fund, 2015c), of the 58 countries listed in Table 1, 11 are currently ineligible for Global Fund support through the new funding model (Argentina, Bosnia and Herzegovina, China, Croatia, Estonia, Jordan, Kazakhstan, Macedonia, Mexico, Montenegro, and Turkey) – accounting for 15% (US\$ 92.2 million) of the US\$ 620 million total investment for harm reduction to date. A further three countries are only eligible via the “NGO Rule” and on certain conditions (Bulgaria, Romania and Serbia), while Russia is receiving funding only through a specially arranged “grace period”.

Of the eligible countries, more than half are classified by the Global Fund as being in “Band 4” – the category of higher income, lower burden countries for which Global Fund support is the most restricted and additional incentive funding is not permitted. Furthermore, 26 of the eligible countries have been labelled by the Global Fund as ‘over-allocated’ (8 countries) or ‘significantly over-allocated’ (18 countries) – meaning that they are “receiving more than what the disease burden and ability-to-pay calculation would indicate” (Global Fund, 2014c), and can expect further reductions in Global Fund support over the coming years.

In recent years, harm reduction programmes have faced closure in the absence of sustainable alternative funding following the withdrawal of Global Fund support (Harm Reduction International, 2014). In Romania, for example, an “HIV outbreak among IDUs in 2011 coincided with a significant reduction of harm reduction service provision due to the ending of the international programmes and funding available from the Global Fund” (Botescu, Abagiu, Mardarescu, & Ursan, 2012). In Serbia, harm reduction services are under increasing threat (EHRN, 2015). In Ukraine, Global Fund spending on HIV is predicted to drop by 50% between 2014 and 2015, while the government's HIV prevention budget has been cut by 71% – with a similar story emerging from Vietnam (OSF, 2014).

The widespread concern is that both of the criteria used to calculate allocations under the new funding model are too blunt. Using only national disease burden data may not adequately reflect concentrated HIV epidemics among people who inject drugs, or in specific regions or cities within a country. Using country income categorisations from the World Bank overlooks vast wealth inequalities within countries and assumes that reaching a certain Gross Domestic Product threshold equates to increased willingness to invest domestic resources in health services for most-at-risk populations – which is very rarely the case. Furthermore, the majority of poor people now live in middle income countries (OSF, 2014; Sumner, 2010), as do the majority of people living with HIV (OSF, 2014), and the majority of people who inject drugs (Harm Reduction International, 2014). According to the Global Fund's own analyses, “Upper-Middle Income” countries account for 18% of the disease burden, yet receive just 8% of the new funding model allocations (Global Fund, 2015d).

Using the data from this study as the baseline, the Global Fund should undertake further analysis as a matter of urgency to measure and understand the impact of the new funding model on harm reduction funding as and when concept notes are submitted and new grant agreements are signed. Such analysis should also inform the development of the Global Fund's new strategy for 2017–2021.

In addition to the country allocations, funding has also been set aside for regional proposals. EHRN was invited to apply as an “early applicant” as part of the transition to the new funding model, and subsequent harm reduction proposals have been submitted or developed in East Africa and Asia. This is a welcome avenue for greater funding for the critical enablers such as advocacy and community systems strengthening.

Conclusions

This article presents the most up-to-date and complete picture of Global Fund financing for harm reduction from 2002 until the roll-out of the new funding model in 2014. It demonstrates that the Global Fund remains a major donor for services that target people who inject drugs – with an estimated US\$ 620 million budgeted through 152 grants.

However, there remains a global crisis in harm reduction funding, which falls far short of the estimated need. Despite the Global Fund receiving a record level of donor pledges in 2013, the strategic shift away from funding middle-income countries may have major implications for harm reduction, especially in Eastern European and Asian countries which are not politically prepared to replace Global Fund resources for these programmes with domestic funding.

The Global Fund's Key Populations Action Plan 2014–2017 includes a commitment to “evaluate the impact of the new funding model in meeting the needs of key populations”. Using these updated data as the baseline, the Global Fund must carefully assess how funding for harm reduction in the new funding model compares to that in the rounds-based model. A portfolio analysis using this same methodology should be conducted once a sufficient number of new funding model grants have been approved (i.e. early 2016) to mitigate against a downturn in investments that is foreseen by some stakeholders.

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